

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03622 41

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powder Mill (Balt)</u> c. LENGTH OF STAY IN 1b <u>6 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3447 Yorkway</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Preble</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McARTHUR</u> <u>72x-3</u> ✓ d. STREET ADDRESS <u>RT. #1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>WIRT</u> First Middle Last <b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>16</u> Year <u>1956</u>				<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov 29, 1885</u> <b>9. AGE</b> (In years last birthday) <u>70</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u> <b>IF UNDER 24 HRS.</b> Hours <u>—</u> Min. <u>—</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>AGRICULTURE</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>W. VA.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>ZER ACORD</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MINNIE BROWN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>29-3-18-2096</u>		<b>17. INFORMANT</b> <u>SON</u> Address <u>3447 Yorkway</u>		<u>BALTIMORE</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Jack Collins</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>JACK COLLINS</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>4-16-56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>4-20-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ELK FORK</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>McARTHUR OHIO</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter B. Bradley, Headtown, W. Va.</u> <b>ADDRESS</b>				<b>24a. REC'D BY REGISTRAR</b> <u>APR 17</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Wm. Kelly</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
STATE OF CALIFORNIA - HATHAWAY 12

BUREAU V. S.

APR 17 1956

RECEIVED

3675

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>			
c. LENGTH OF STAY IN 1b <u>34</u> days				d. STREET ADDRESS <u>Box 75</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY</u>		First		Middle <u>(NMT)</u>		Last <u>AMERICA</u>	
4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1956</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/1/89</u>		9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph America</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212-32-2942</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY THROMBOSIS</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 6</u> , 19 <u>56</u> to <u>April 9</u> , 19 <u>56</u> that I saw the deceased alive on <u>March 19</u> and that death occurred at <u>3:35 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>4/10/56</u>							
ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D. <u>VAH, Fort Howard, Md.</u>				DATE SIGNED <u>4/10/56</u>			
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>				DATE SIGNED <u>4/10/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> M.D. <u>Charles R. Law</u> Mortuary 802-04 Madison Ave. Balt., Md.				24a. REC'D BY REGISTRAR <u>4/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>Nauman D. Foster</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 17 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

0362431  
Reg. Dist. No.

3676

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2206 Pine Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>	
d. STREET ADDRESS <b>2206 Pine Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ReEtta E.</b> Middle <b>Amoss</b> Last <b>Amoss</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4,</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1909</b> 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>
13. FATHER'S NAME <b>Walter F. Buppert</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Cook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-20467</b>	
17. INFORMANT <b>Ralph E. Amoss</b>		Address <b>2206 Pine Ave. 7</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>592X</b> DUE TO <b>Chronic Congestive Heart Failure. c</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic nephritis - none -</b> DUE TO (c) <b>Chronic nephritis - none -</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day - 5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>APRIL 1, 1956</b> , to <b>APRIL 4, 1956</b> , that I last saw the deceased alive on <b>APRIL 4, 1956</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas E. Wheeler</b>		ADDRESS (Street, city or town, state) <b>3601 Clymar Rd - Baltimore -</b>	
PHYSICIAN'S NAME (Type) <b>Thomas E. Wheeler</b>		DATE SIGNED <b>4/5/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/7/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Howard Co. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd</b>	
24a. REC'D BY REGISTRAR <b>9 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. J. W. Martin</b>	

# CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		DATE		PLACE		REASON		DATE		PLACE	
OCCUPATION		DATE		PLACE		REASON		DATE		PLACE	
CAUSE OF DEATH		DATE		PLACE		REASON		DATE		PLACE	
SIGNATURE		DATE		PLACE		REASON		DATE		PLACE	

BUREAU V. S.

APR 9 1956

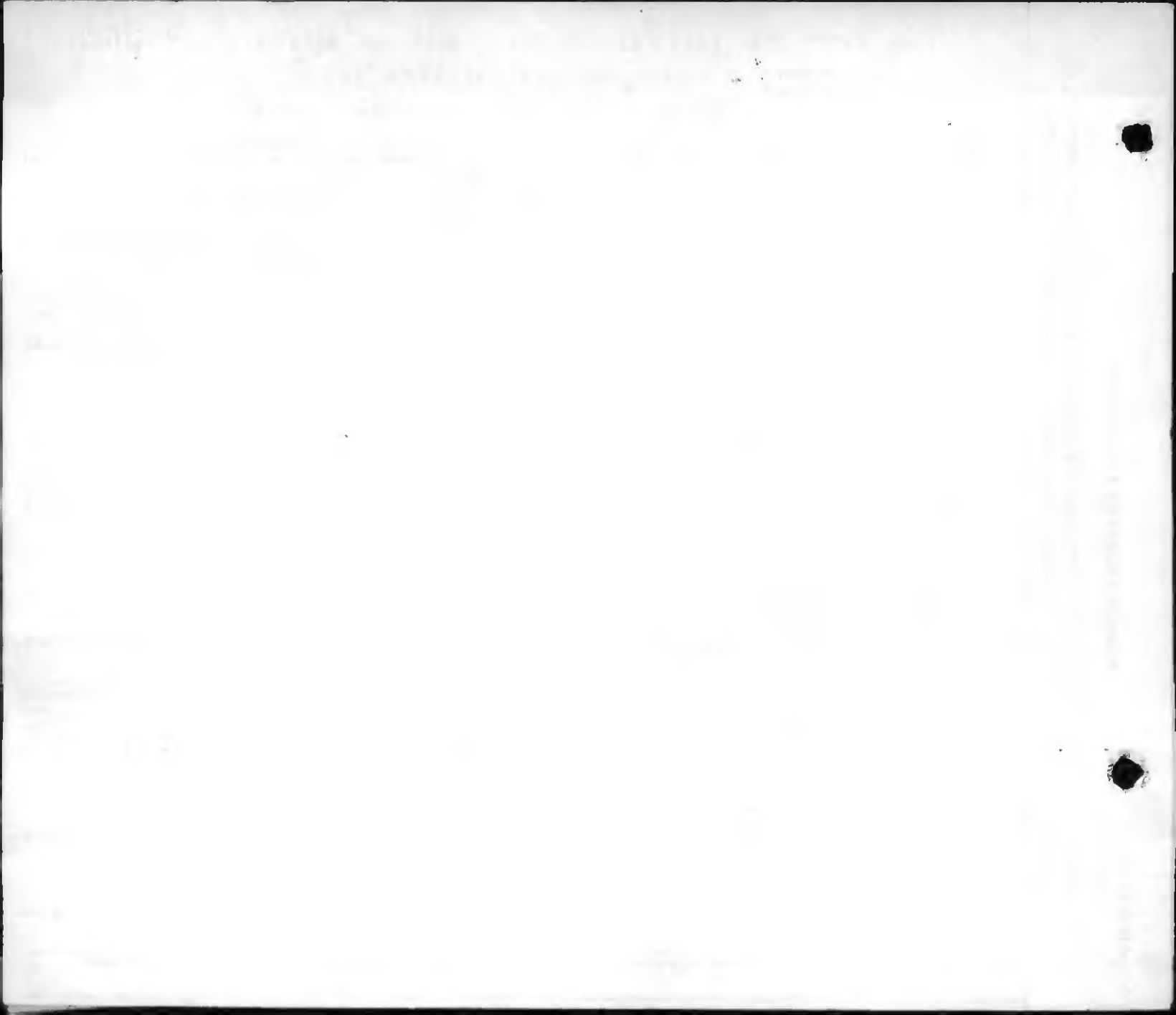
RECEIVED

## 3677 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <b>Goldie Josephine Anderson</b>			2. DATE OF DEATH <b>April 26, 1956</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland Catonsville, Baltimore</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1133 Baker Avenue.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Catonsville</b>		
D. STREET ADDRESS (If rural, give location) <b>1133 Baker Avenue.</b>			E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 25, 1882</b>		9. AGE (In years last birthday) <b>73</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>George T. Schaeffer</b>			14. MOTHER'S MAIDEN NAME <b>Sarah E. Hughes</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT ADDRESS <b>Samuel D. Anderson 1133 Baker Ave.</b>		
18. <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the stomach</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>		
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8 Jan 1956</b> to <b>26 April 1956</b> , that (I) (we) last saw the deceased alive on <b>26 April 1956</b> , and that death occurred at <b>12:20 P. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>G. M. H. Hennings Jr.</b> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS <b>601 Winans Way</b>		23C. DATE SIGNED <b>28 April 56</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/30/56</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>April 30 1956</b>		REGISTRAR'S SIGNATURE <b>H. H. Hedrick</b>		25. FUNERAL DIRECTOR ADDRESS <b>H. H. Hedrick 1913 N. Baltimore</b>	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



3678

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uppersco Rural</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OF INSTITUTION</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ABRAM-HUBER-ARMACOST</u>		4. DATE OF DEATH <u>April 12 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24-1882</u>
9. AGE (in years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trading</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D. Mitchell Armacost</u>		14. MOTHER'S MAIDEN NAME <u>Frances M. Wisner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-4690</u>	
17. INFORMANT <u>Howard H. Armacost, Uppersco Md</u>		Address <u>Uppersco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis</u> (c) <u>General Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>15 yrs</u>	
PART II—OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1940</u> to <u>April 13 56</u> , that I last saw the deceased alive on <u>April 6 56</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.		DATE SIGNED <u>4-13-56</u>	
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M.C. PORTERFIELD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 15 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McGraw</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. C. Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 4-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Lane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

3672

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

1. Name of Deceased: [Faint text]

2. Sex: [Faint text]

3. Age: [Faint text]

4. Date of Birth: [Faint text]

5. Place of Birth: [Faint text]

6. Date of Death: [Faint text]

7. Time of Death: [Faint text]

8. Cause of Death: [Faint text]

9. Manner of Death: [Faint text]

10. Signature of Physician: [Faint text]

11. Signature of Registrar: [Faint text]

12. Signature of Coroner: [Faint text]

13. Signature of Medical Examiner: [Faint text]

14. Signature of Pathologist: [Faint text]

15. Signature of Forensic Scientist: [Faint text]

16. Signature of Toxicologist: [Faint text]

17. Signature of Anthropologist: [Faint text]

18. Signature of Archaeologist: [Faint text]

19. Signature of Historian: [Faint text]

20. Signature of Linguist: [Faint text]

21. Signature of Philologist: [Faint text]

22. Signature of Philosopher: [Faint text]

23. Signature of Scientist: [Faint text]

24. Signature of Engineer: [Faint text]

25. Signature of Architect: [Faint text]

26. Signature of Artist: [Faint text]

27. Signature of Musician: [Faint text]

28. Signature of Actor: [Faint text]

29. Signature of Dancer: [Faint text]

30. Signature of Athlete: [Faint text]

31. Signature of Politician: [Faint text]

32. Signature of Lawyer: [Faint text]

33. Signature of Judge: [Faint text]

34. Signature of Minister: [Faint text]

35. Signature of Priest: [Faint text]

36. Signature of Rabbi: [Faint text]

37. Signature of Imam: [Faint text]

38. Signature of Monk: [Faint text]

39. Signature of Nun: [Faint text]

40. Signature of Bishop: [Faint text]

41. Signature of Pope: [Faint text]

42. Signature of Emperor: [Faint text]

43. Signature of King: [Faint text]

44. Signature of Queen: [Faint text]

BUREAU V. 1

APR 17 1956

RECEIVED

3679

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wayne Conv. Home</u>				d. STREET ADDRESS <u>Maple + Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>ARMOUR</u> Last <u>ARMOUR</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1, 1883</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>29</u> Hours <u>19</u> Min <u>56</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Grace Fairall, Openton</u> Address <u>Openton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cachexia</u> DUE TO <u>Chronic Colitis.</u> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ruptured Appendix Feb 1956</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1954</u> to <u>29 April 1956</u> that I last saw the deceased alive on <u>28 April 1956</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Mc Grath M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>1707 Edmondson Ave Catonsville 28 MD</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried May 1, 56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Mc Grath Son</u>				ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>5/3/56</u>	
						24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director must sign the certificate as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department for burial, cremation, or removal, and in any event within 72 hours after death.

MAY 7 1956

RECEIVED  
V. E. L.

3680

## CERTIFICATE OF DEATH

Item 49, Film 0196, 4/30/56 m

Reg. Dist. No. 38

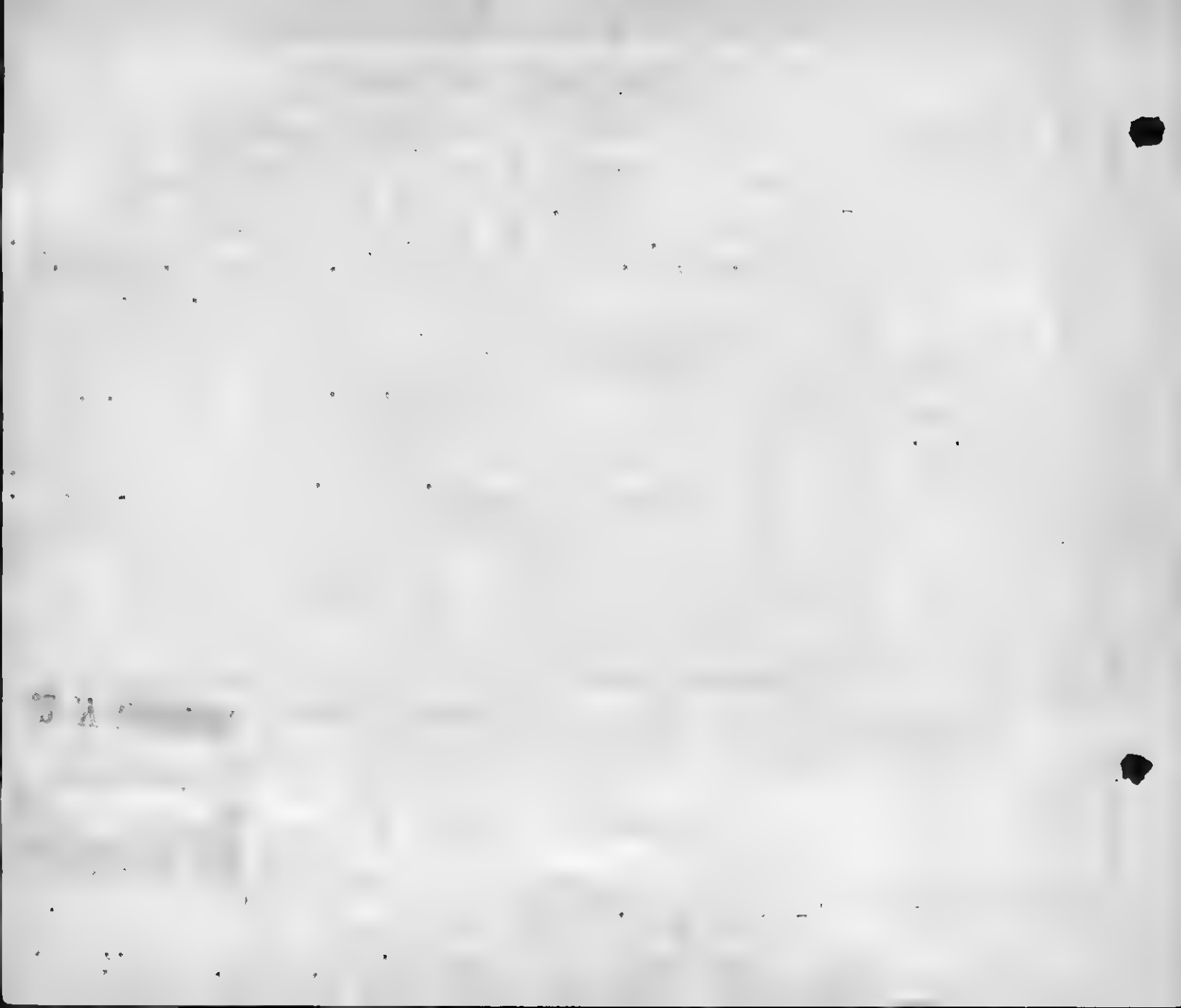
<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Towson</b>		LENGTH OF STAY (in this place) <b>3 yrs.</b>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>812 Regester Ave. Balto. 12, Md.</b>		STREET ADDRESS (If rural, give location) <b>Shirley Hotel Md. 205 W. Madison St., Balto. 1,</b>					
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Virginia</b>		(Middle) <b>Bacon</b>		(Last) <b>Armstrong</b>		(Month) (Day) (Year) <b>Apr. 23, 1956</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>June 13, 1861</b>	<b>9. AGE last birthday</b> <b>95 94 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Monkton, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Wm. M. Bacon</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha Green</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Alva N. Martin Greenway Apts. Balto. 18, Md.</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE</b> (A) <b>Coronary Thrombosis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Immediate</b>			
<b>ANTECEDENT CAUSE(S)</b> (B) <b>Generalized Arteriosclerosis</b>				<b>20 years</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C)							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Sept. 1947, to Apr. 23, 1956, that I last saw the deceased alive on Apr. 17, 1956, and that death occurred at 8:10 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>William F. Pearce</b>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. 2105 N. Charles St. Baltimore 18 Md.</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>4-26-1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. James Cemetery</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mabel Gray</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Henry W. Jenkins &amp; Sons Co., Inc.</b>		<b>ADDRESS</b> <b>4905 York Rd., Balto. 12, Md.</b>	
<b>DATE</b>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. All this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03629

3681

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria &amp; Quaker Rd</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Magdalen Baierl</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>15</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 22, 1881</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday If under 1 year: Months _____ Days _____ If under 24 hrs: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Rochester N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Baierl</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kohlmaier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff Md</u>			

### 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) _____	<u>Intestinal obstruction</u>	<u>8 days</u>
Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	<u>Carcinoma of ascending colon</u>	<u>6 yrs</u>
(c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1952., to April 15, 1956., that I last saw the deceased alive on Dec. 13, 1955., and that death occurred at 1:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>4-17-56</u>	<u>VILLA MARIA CEM.</u>	<u>NOTCH CLIFF NORTONSON, MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/16/56</u>	<u>Michael Baierl</u>	<u>Charles J. Jailer</u>	<u>901 S. CONKLING ST. BALTO, MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803630

3682

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

Helen E. Baker

2. DATE  
OF  
DEATH

April 7, 1956

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore County

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

217 Dunkirk Road

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

217 Dunkirk Road

C. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Aug. 10, 1882

9. AGE (In years last birthday)

73

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles F. Hamilton

14. MOTHER'S MAIDEN NAME

Erma Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO. 220-01-2083A

17. INFORMANT

ADDRESS

Miss Helen Hamilton, 107-50-100th St.

CAUSE OF DEATH

Richmond 9 INTERVAL BETWEEN ONSET AND DEATH

18. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

QUE TO

Arteriosclerosis  
L. V. Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21D TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from Jan. 1948 to Apr. 7, 1956, that (I) (we) last saw the deceased alive on Apr. 7, 1956, and that death occurred at 11:00 Am., from the causes and on the date stated above.

23A. SIGNATURE

Helen Janney

M.D.

23B. ADDRESS

7101 Harford Rd.

23C. DATE SIGNED

4/7/56

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/10/56

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county) (State)

Edmondson Ave, Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm Cook - Balt Inc

25. FUNERAL DIRECTOR

ADDRESS

Wm Cook - Balt Inc 6009 Harford Rd

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK--DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER THE DEATH.



3683

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>		c. LENGTH OF STAY IN 1b <b>39 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 Oella Ave.</b>		d. STREET ADDRESS <b>109 Oella Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>AMANDA</b> Last <b>BARNES</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1956.</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 13, 1889.</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Laybright G. Welker</b>		14. MOTHER'S MAIDEN NAME <b>Emma McElroy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lawrence L. Barnes</b>		Address <b>Oella, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of sigmoid with metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1954</b> to <b>4/16, 1956</b> , that I last saw the deceased alive on <b>4-16, 1956</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George E Burgtorf</b> M.D.		ADDRESS (Street, city or town, state) <b>Elm City, Md.</b> DATE SIGNED <b>4/17/56</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE E BURGTORF, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 19/56.</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Chambersburg, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Soud</b> ADDRESS <b>Cottonville 28, Md</b>		24a. REC'D BY REGISTRAR <b>DATE 4/19/56</b>	24b. REGISTRAR'S SIGNATURE <b>T.E. Barry</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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9.5

1000012

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3666

## CERTIFICATE OF DEATH

03632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethrope</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethrope</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1818 Winanns Ave</b>		d. STREET ADDRESS <b>1818 Winanns Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Thelma May Barry</b>		4. DATE OF DEATH <b>April 15, 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 26, 1900</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <b>Augustus W. Bryan</b>	
14. MOTHER'S MAIDEN NAME <b>Mary R. Green</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>John M. Barry, 1818 Winanns Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepato Renal Syndrome</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Secondary to Carcinomatosis</b> DUE TO (c) <b>Primary Lesion - CH Rectum</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12/4</b> 19 <b>50</b> , to <b>1/15</b> 19 <b>56</b> , that I last saw the deceased alive on <b>1/14</b> 19 <b>56</b> , and that death occurred at <b>5:07 p. m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md</b> DATE SIGNED			
ACTUAL SIGNATURE <b>John C. Barry, M.D.</b>		PHYSICIAN'S NAME (Type) <b>John C. Barry, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 18, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Ave.</b>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <b>John M. Barry</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 19 1900

RECEIVED

3684

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>5 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Miss Odd's Nursing Home</b> <b>301 W. Chesapeake Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elizabeth Henckel Barth</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/9/1877</b>	
9. AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Mt. Savage Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>John Henckel</b>				14. MOTHER'S MAIDEN NAME <b>Ellem Findlay</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Margaret E. Uhl.</b> Address <b>Mt. Savage Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic C-V disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>3/7</b> , 19 <b>55</b> , to <b>4/25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/25</b> , 19 <b>56</b> , and that death occurred at <b>3:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Tos. A. Sedlak</b> , M.D. <b>200 W. Penna. Ave</b> <b>4/25/56</b> PHYSICIAN'S NAME (Type) <b>Tos. A. SEDLACK</b> <b>Towson 4</b> <b>Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/27/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Georges Church Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Savage Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins and Sons Co., Inc.</b> <b>4905 York Road, Balto., 12. Md.</b>				24a. REC'D BY REGISTRAR <b>APR 26 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Michel Gray</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 26 1956  
BUREAU OF



3685

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Howard, Md.</u>				c. LENGTH OF STAY IN 1b <u>137 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. STREET ADDRESS <u>2107 Elsinor Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>WILBUR</u> Middle <u>C.</u> Last <u>BARTON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/97</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Monkton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Barton</u>				14. MOTHER'S MAIDEN NAME <u>Anna Turmont</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA WITH METASTASIS</u> <u>16.2x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>7 Months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>VA</u> attended the deceased from <u>November 30, 1955</u> , to <u>April 15, 1956</u> , that <u>VA</u> saw the deceased alive on <u>12/12/55</u> and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold S. Tidler</u> M.D.				ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Maryland</u>		DATE SIGNED <u>4/15/56</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD S. TIDLER, M. D.</u>				ADDRESS <u>VAH, Fort Howard, Maryland</u>		DATE SIGNED <u>4/15/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4.19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hereford Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hereford, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tidler &amp; Sons, Inc.</u> <u>Wm. J. Tidler &amp; Sons, Inc., North &amp; E. Ays.</u> <u>Baltimore, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. L. Tidler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. R.

APR 18 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

3651

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTO.		MARYLAND		STATE MD		COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN DUNDALK 22		14 YRS		TOWN DUNDALK			
HOSPITAL OR STREET ADDRESS 7013 DUNBAR Rd				STREET ADDRESS (If rural give location) 7013 DUNBAR Rd			
3. NAME OF DECEASED (Type or Print) MINNIE SAUNDERS BASKIETTE				4. DATE OF DEATH (Month) (Day) (Year) 4-19 1956			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH NOV 6, 1874	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME SAUNDERS				14. MOTHER'S MAIDEN NAME JNK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE	17. INFORMANT & ADDRESS MRS. SCOTT N. STINER - SISTER			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Carcinoma Generalized				INTERVA. BETWEEN ONSET AND DEATH 6 months			
ANTECEDENT CAUSE(S) DUE TO (B) Primary Breast Cancer				2 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 5, 1955, to April 5, 1956; that I last saw the deceased alive on Dec 18, 1955; and that death occurred at 3:25 P.M. from the causes and on the date stated above.							
SIGNATURE J. H. Morrison				ADDRESS 3 Kinship Rd Balto 22 DATE SIGNED 20 Apr 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4-21-56		NAME OF CEMETERY OR CREMATORY OAK LAWN		LOCATION (City, town, or county) BALTO. CO. MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Wm. Kelly		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE				Arthur P. Buckley, Dundalk, Md.			

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

W. A. JONES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3686

## CERTIFICATE OF DEATH

03636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>373 NICHOLSON ROAD.</b>		d. STREET ADDRESS <b>373 Nicholson Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Benhoff</b> Last <b>Benhoff</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27th</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10th, 1893</b>
9. AGE (In years lost birthday) <b>63 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Charles Cooksey</b>	
14. MOTHER'S MAIDEN NAME <b>Fannie Kromling</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>	
16. SOCIAL SECURITY NO		17. INFORMANT <b>Edward Benhoff (Husband) Above.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 11, 1951</b> to <b>April 27, 1956</b> , that I last saw the deceased alive on <b>April 27, 1956</b> , and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Joseph Miceli</b> M.D. <b>423 Eastern Ave 21, Md 4/20/56</b>		ADDRESS (Street, city or town, state) <b>Essex</b> DATE SIGNED <b>4/20/56</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>Burial April 30th, 56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	22d. LOCATION (City, town, or county) (State) <b>Eastern Blvd., Balto Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. G. Connolly</b>		24a. REC'D BY REGISTRAR <b>MAY 1 1956</b>	
ADDRESS <b>418 Eastern Blvd.</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>	

S. A. C. 100-100000

3687

## CERTIFICATE OF DEATH

03637

Reg. Dist. No. 38

Item 2, Film 6197 5-1'-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Parkville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Parkville		Baltimore 34	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Oak Haven Nursing Home				STREET ADDRESS 3422 Joppa Road (If rural give location) Oak Haven Nursing Home			
3. NAME OF DECEASED (Type or Print) FANNIE KLINE BICKFORD (First) (Middle) (Last)				4. DATE OF DEATH April 21, 1956 (Month) (Day) (Year)			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH November 24, 1877	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Kline				14. MOTHER'S MAIDEN NAME Amanda Palmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Walter Carswell, Timonium, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Anterior circulation CVD				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/1/56, 19, to 4/21/56, 19, that I last saw the deceased alive on 4/20/56, 19, and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
SIGNATURE Harold A. Grott		M.D. 8100 Harford Rd.		DATE SIGNED 4/23/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 24, 1956		NAME OF CEMETERY OR CREMATORY Sherwood Episcopal Cem.		LOCATION (City, town, or county) Cockeysville, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE A. H. Bacon		25. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS Towson, Md.	
DATE 4/23/56							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED  
MAY 2 1968  
BUREAU V. S.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03638

3688

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Mt. Wilson State Hospital</b>				STREET ADDRESS (If rural give location) <b>911 St Paul Street</b>			
3. NAME OF DECEASED (Type or Print)			(First) <b>WILLIAM</b>		(Middle) <b>G</b>		(Last) <b>BLOSS</b>
4. DATE OF DEATH			(Month) <b>April</b>		(Day) <b>16</b>		(Year) <b>1956</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-17-1904</b>		9. AGE last birthday <b>51</b> yrs.	IF UNDER 1 YEAR Months <b>12</b>	IF UNDER 24 HRS. Days <b>16</b> Hours <b>12</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SAILOR</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WILLIAM BLOSS</b>				14. MOTHER'S MAIDEN NAME <b>ALICE SEYMOUR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>UNK.</b>			16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT & ADDRESS <b>Hospital Records</b>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>TUBERCULOUS MENINGITIS</b>						<b>6 days</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>PULMONARY TUBERCULOSIS</b>						<b>40 days</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3-6-1956</b> to <b>4-16-1956</b> , that I last saw the deceased alive on <b>4-16-1956</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>William Newman</b>				ADDRESS (Street, city, town, state) <b>Mt. Wilson, Maryland</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIED</b>		DATE THEREOF <b>4/14/56</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery, Baltimore, Maryland</b>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <b>APR 21 9 1956</b>		REGISTRAR'S SIGNATURE <b>Mrs. Dorothy Kimmell</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>WM COTY INC 1217 St. Paul St</b>		ADDRESS	

RECEIVED  
APR 10  
BUREAU A.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03639

3689

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Randallstown</u>				TOWN <u>Randallstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Offutt Road</u>				STREET ADDRESS (If rural give location) <u>Offutt Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Anna S. Blottenberger</u>				<u>Apr. 7 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>Dec. 4, 1874</u>	
9. AGE last birthday <u>81</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John Popp</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Walter A. Proctor - Offutt Rd.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on 4/18, 19 56, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE <u>Lorraine A. Plonker</u> M.D. ADDRESS DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/11/1956</u>		<u>Lorraine Cemetery</u>		<u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR			
<u>4-11-56</u>		<u>J. C. [Signature]</u>		<u>Edward A. [Signature]</u> 4600 Liberty Hgts. Ave.			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3690

## CERTIFICATE OF DEATH

03640

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
				d. STREET ADDRESS <b>415 N. Pine Street</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>G.</b> Last <b>BOOKER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/19/99</b>	
9. AGE (In years last birthday) <b>56 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Henry Booker</b>				14. MOTHER'S MAIDEN NAME <b>Nannie Barrett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <input checked="" type="checkbox"/> <b>WW I</b>				16. SOCIAL SECURITY NO. <b>213-20-2244</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>UREMIC CONVULSION</b> <b>260A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>RENAL INSUFFICIENCY</b> DUE TO (c) <b>KL MEISTIEL'S WILSON'S DISEASE</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>10 years</b> <b>12 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March 28, 1956</b> to <b>April 14, 1956</b> and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>4/15/56</b>							
ACTUAL SIGNATURE <b>Harold S. Tidler</b> M.D. <b>VAH, Fort Howard, Maryland</b>							
PHYSICIAN'S NAME (Type) <b>HAROLD S. TIDLER, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arbutus, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raynor Sanders Funeral Home 217 E. Preston St., Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>4/18/56</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Fisher</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 19 1936

RECEIVED

03641

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3691

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Immediately</u> LENGTH OF STAY (In this place) <u>11 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Immediately North of Balto. City Line</u>	
TOWN <u>North of Balto. City Line</u>		TOWN <u>Immediately North of Balto. City Line</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5908 Liberty Road</u>		STREET ADDRESS (If rural, give location) <u>5908 Liberty Road</u> 7	
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>Wallace</u> (Last) <u>Boone</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>27</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Nov. 6, 1885</u>
9. AGE last birthday <u>70</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Industrial Engineer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John W. Boone</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rosa Bowersox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>James K. Hughlett</u> 5908 Liberty Road 7	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Gastritis, duodenal ulcer, cancer</u>		
Antecedent cause(s) (b) <u>Chronic gastritis, duodenal ulcer, cancer</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic gastritis, duodenal ulcer, cancer</u>		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 26, 1956, 1953, to Apr. 27, 1956; that I last saw the deceased alive on Nov. 26, 1956; and that death occurred at 3:14 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 1, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)
DATE REC'D BY LOCAL REG. <u>April 30, 1956</u>	REGISTRAR'S SIGNATURE <u>C. W. Hedlund</u>	24. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>	ADDRESS <u>3631 Falls Road</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3692

## CERTIFICATE OF DEATH

03642

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2yrs. 6mos. 27days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Spring Grove State Hospital</b>			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Hurst</b> Last <b>Brent</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-6-1874</b>		9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sea Captain</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Thomas Brent</b>			
14. MOTHER'S MAIDEN NAME <b>Susan Hurst</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>			
16. SOCIAL SECURITY NO <b>Unknown</b>				17. INFORMANT <b>Records Spring Grove State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. s. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>9-15-</b> , 19 <b>53</b> , to <b>4-11-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-10-</b> , 19 <b>56</b> , and that death occurred at <b>2:50A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b> DATE SIGNED <b>4-11-56</b>							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				M.D. <b>Spring Grove State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 13, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old Morrattico Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Kilmarnock, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>				ADDRESS <b>1900 Eutaw Place</b>		24a. REC'D BY REGISTRAR DATE <b>4/12/56</b>	
24b. REGISTRAR'S SIGNATURE <b>V E Perry</b>							

GOVERNMENT V. S.

APR 10 1976

10-10-76

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3693 CERTIFICATE OF DEATH

03643

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL VILLAGE</b>		c. LENGTH OF STAY IN TB <b>6 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ESSEX RD</b>		d. STREET ADDRESS <b>922 Wildwood Parkway</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth</b> First Middle Last <b>Aristow</b>		4. DATE OF DEATH Month <b>4</b> Day <b>4</b> Year <b>1956</b>	
5 SEX <b>F</b>	6. COLOR OF RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 25, 1883</b>
9. AGE (In years last birthday) <b>72</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Housewife</b>		10b. KIND OF BUSINESS, OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Pedberg</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Sewald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Edwin L. Pierpont, M.D.</b> Address <b>8204 Liberty Rd. Balto 7</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Vascular</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Removal of Vessels</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 1953</b> to <b>April 4, 1956</b> , that I last saw the deceased alive on <b>April 4, 1956</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Edwin L. Pierpont</b> M.D.		ADDRESS (Street, city or town, state) <b>8204 Liberty Rd. Balto 7, Md.</b> DATE SIGNED <b>4/5/56</b>	
PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>		<b>8204 LIBERTY RD. BALTO. 7, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>April 7, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>East View Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b> ADDRESS <b>Willemsville</b>		24a. REC'D BY REGISTRAR DATE <b>4/10/56</b>	24b. REGISTRAR'S SIGNATURE <b>Edwin L. Pierpont</b>

RECEIVED

APR 10 1956

JOHNSON V. S.

3694

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sherwood Rd.</b>				d. STREET ADDRESS <b>Sherwood Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Alexander</b> Middle <b>Dance</b> Last <b>Brooks</b>				4. DATE OF DEATH Month <b>4</b> Day <b>15</b> Year <b>56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-8-1862</b>		9. AGE (In years last birthday) <b>93</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>National Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel B. Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ensor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-14-9873</b>		17. INFORMANT <b>G. Milton Brooks,</b> Address <b>Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Constrictive Heart Disease</b> DUE TO <b>Parkinson's Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, General.</b> DUE TO (c) <b>unk</b>						INTERVAL BETWEEN ONSET AND DEATH <b>22 days</b> <b>5 yrs</b> <b>unk</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/15</b> , 19 <b>55</b> to <b>4/15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/15</b> , 19 <b>56</b> , and that death occurred at <b>8:33 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Bennett A. Stoen</b> M.D.				ADDRESS (Street, city or town, state) <b>Lutherville</b> DATE SIGNED <b>4/16/56</b>			
PHYSICIAN'S NAME (Type) <b>Bennett A. Stoen</b>				<b>Lutherville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Black Rock Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Butler, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>				ADDRESS <b>Sparks, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 18 April 56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Anne Arishead McRae</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 20 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803645  
3695 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>104A Winters Lane</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u> STREET ADDRESS (If rural give location) <u>104A Winters Lane</u>			
3. NAME OF DECEASED: (Type or Print) <u>Elizabeth</u> (First) <u>Brown</u> (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 10</u> 19 <u>56</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>April 12, 1880</u>	
9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>John Howard</u>				14. MOTHER'S MAIDEN NAME: <u>Eliza Anna Bond</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr Harry Brown 104A Winters Lane</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						22 days	
ANTECEDENT CAUSE (B) <u>Hypertensive Arterio-sclerosis</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:						19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID (City or town) (County) (State)						21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3-19-</u> , 19 <u>56</u> , to <u>4-10-</u> , 19 <u>56</u> that I last saw the deceased alive on <u>4-10-</u> , 19 <u>56</u> , and that death occurred at <u>5.30 PM</u> , from the causes and on the date stated above. <u>56</u> SIGNATURE <u>C. H. Maloney</u> ADDRESS <u>57 Winters Lane, Catonsville, Md.</u> M.D. <u>57 Winters Lane, Catonsville, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Western State Cem</u>		LOCATION (City, town, or county) (State) <u>Catonsville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-1</u>		REGISTRAR'S SIGNATURE <u>C. H. Maloney</u>		24. FUNERAL DIRECTOR <u>Mr. Francis C. Hensley</u>		ADDRESS <u>578 W. ...</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3696

### CERTIFICATE OF DEATH

03646  
33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quinn's Mills, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>4 1/2 yrs.</u>		d. STREET ADDRESS <u>2911 N. Calvert St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julian</u> Middle <u>Hirault</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unascertained</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Hinault</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia with hydro and pyro nephrosis with stones,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>multilobar - bilaterally</u> DUE TO (c) <u>Tuberculosis moderately severe with cavities, bilaterally.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Admitted with T.F. 9/21/51</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericarditis, fibrous, chronic.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>September 24, 19 51</u> , to <u>April 9, 19 56</u> , that I last saw the deceased alive on <u>April 9, 19 56</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u> <u>Rosewood St. Tr. School, Quinn's Mills, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>	22d. LOCATION (City, town, or county) (State) <u>Quinn's Mills Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Line. Sons Rusttown</u>		24a. REC'D BY REGISTRAR DATE <u>4-12-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary B. Shive</u>			

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11-11-11

3652

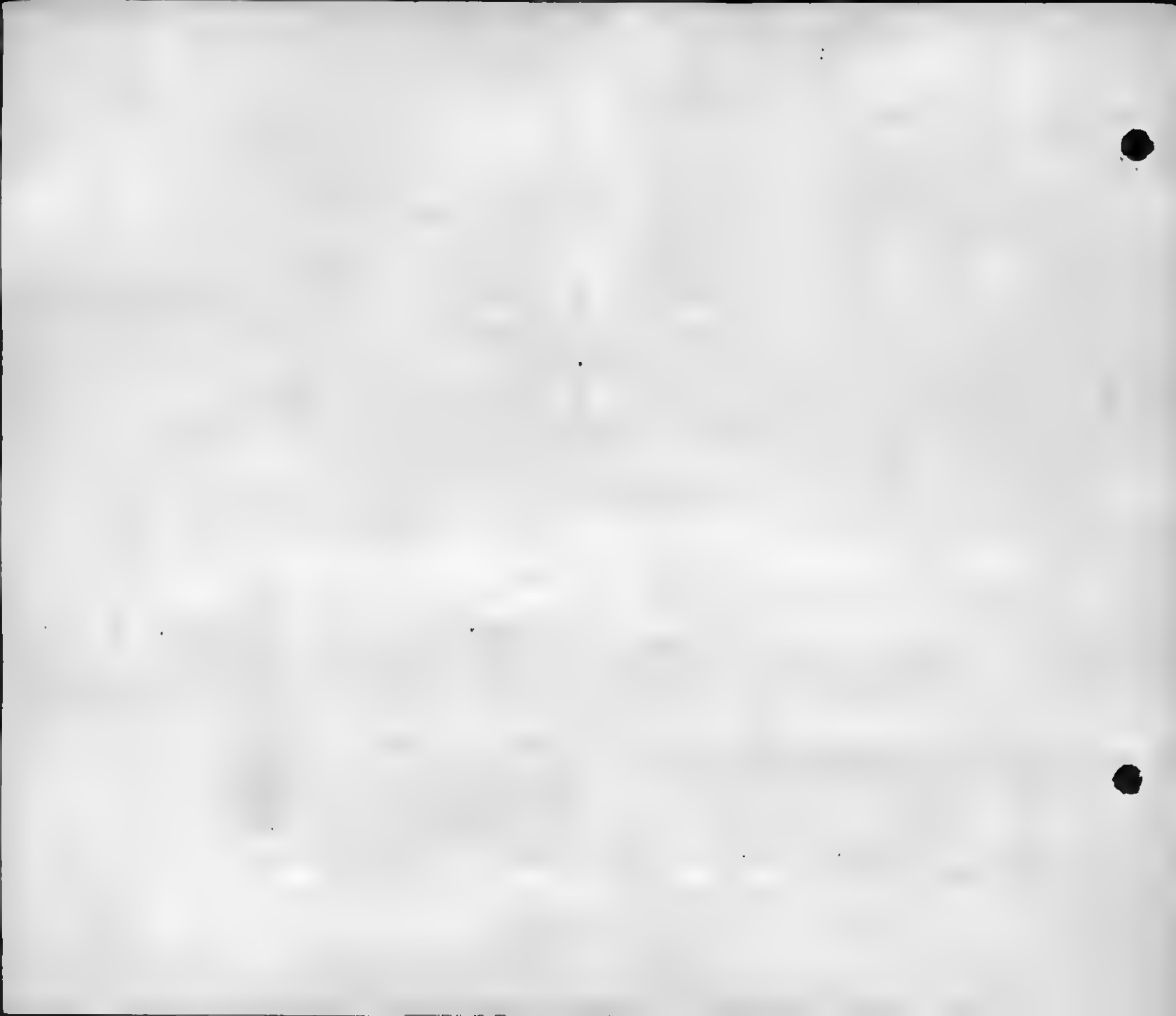
## CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR FILING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lundalk</u>	STATE <u>Md.</u> COUNTY <u>Balto.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lundalk</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>712 S. 51st</u>	STREET ADDRESS (If rural give location) <u>712 S. 51st St.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Rose L. Browning</u>		OF DEATH: <u>4/8/56</u> 19 <u>56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE - MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>2/2/89</u>
9. AGE last birthday <u>67</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Md.</u>	11. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	
13. FATHER'S NAME: <u>George Holland</u>		14. MOTHER'S MAIDEN NAME: <u>Fannie Horn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>		17. INFORMANT & ADDRESS: <u>Leone Kesselring 712 S. 51st St.</u>	
16. SOCIAL SECURITY NO.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4. IMMEDIATE CAUSE (A) DUE TO <u>Pulmonary edema</u>			<u>2 days</u>
ANTECEDENT CAUSE (B) DUE TO <u>Coronary infarction</u>			<u>1 year</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Artero-Sclerosis (Hypertension)</u>			<u>6 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Aug.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/8</u> , 19 <u>56</u> , and that death occurred at <u>6 a</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Morris A. Jacob</u>		DATE SIGNED <u>4/9/56</u>	
M.D. <u>1010 North Point - Rd.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Balto.</u>	
DATE THEREOF <u>4/10/56</u>		LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/10/56</u>		24. FUNERAL DIRECTOR <u>Wm. C. McKim 1217 St. Paul St.</u>	
REGISTRAR'S SIGNATURE		ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH  
3697 - CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

03648

Item 2, Vol. 4195 4-16-56 et

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armacost Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>1908 Park Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Marie</u> (Middle) <u>F</u> (Last) <u>Buckley</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>3</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 10, 1889</u>
9. AGE last birthday <u>66</u> yrs.		10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Solomon H. Freburger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Haggerty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. John L. Buckley, Jr. 100 Edgevale Road</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>
(a) Immediate cause <u>Arteriosclerotic degenerative C.V.D.</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Chronic Nephritis &amp; uremia.</u>		
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. <u>Residuals of left hemiplegia</u>		<u>12 hrs.</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Uterine fibroids with uterine hemorrhage</u>
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?

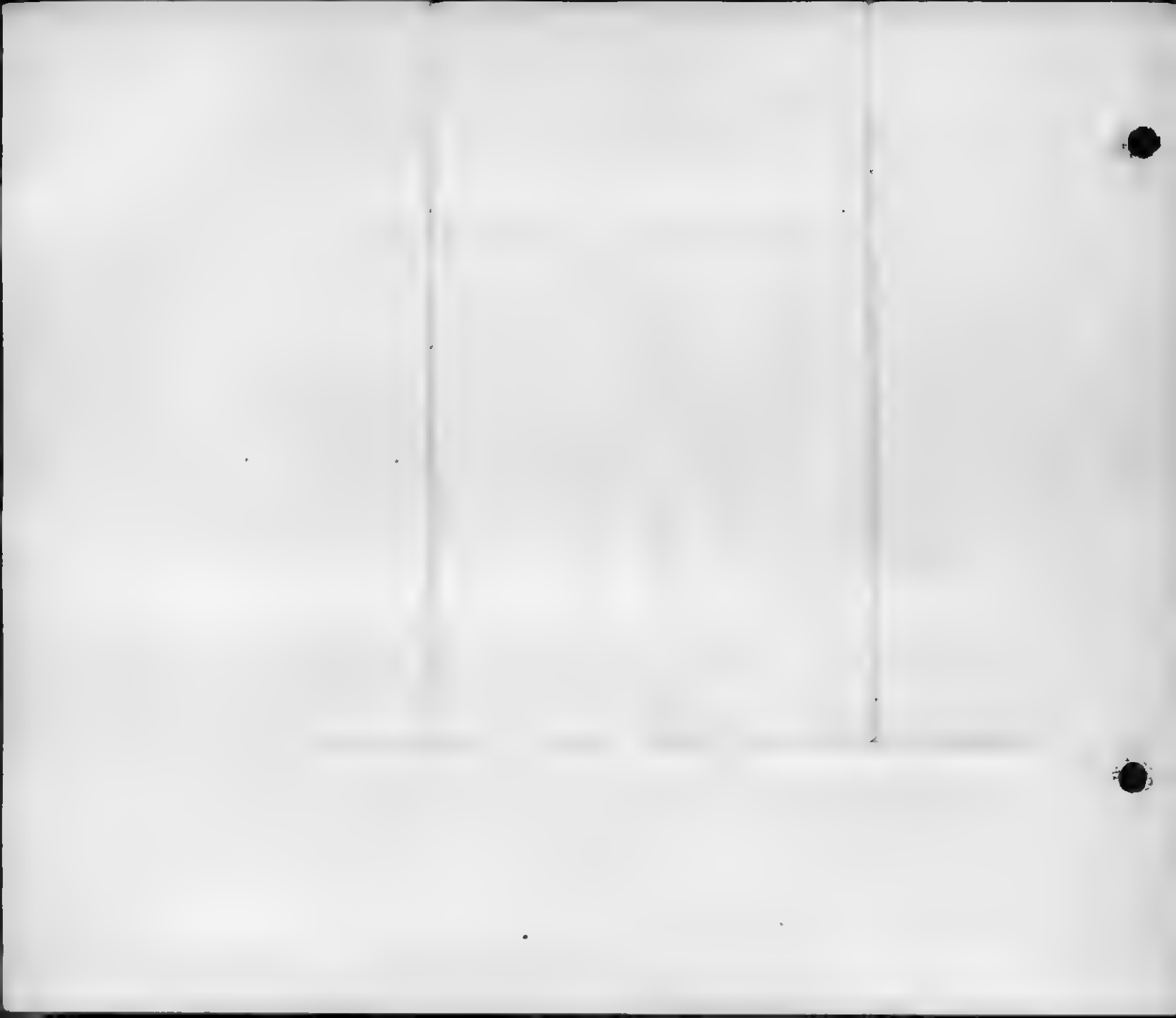
22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE (Degree or title) Joseph E. Muse Jr. M.D. ADDRESS 5 West 29th St. Balto 18. Md DATE SIGNED 4 Apr. '56

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Apr. 6, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG. <u>  </u>		24. FUNERAL DIRECTOR <u>H. W. Meador &amp; Son 805 N. Calvert St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

3698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>28 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>						d. STREET ADDRESS <b>22 N. EAST AVENUE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD J. BURKE</b>						4. DATE OF DEATH Month Day Year <b>APRIL 29, 1956</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-6-96</b>		9. AGE (In years last birthday) yrs. <b>59</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPEFITTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OIL COMPANY</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM A. BURKE</b>						14. MOTHER'S MAIDEN NAME <b>ELIZABETH MYER</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WW-1</b>		17. INFORMANT Address <b>CLIN. REC., VET. ADM. HOSP., FORT HOWARD, MARYLAND</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMPHYSEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CCR PULMONALE</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 1, 1956</b> , to <b>April 29, 1956</b> , and that death occurred at <b>8:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>4/30/56</b>											
ACTUAL SIGNATURE <b>Donald D. Mark</b> M.D.											
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>5-3-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</b>				22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Moran Funeral Home, 3000 E. Baltimore St., Baltimore, Md.</b>						24a. REC'D BY REGISTRAR DATE <b>5/2/56</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Larkins</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 2 1956

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3599 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03650

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River Md.</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GLEN L. MARTIN DISP PHARM</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore.</b> d. STREET ADDRESS <b>2537 Robb St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William F. Burke.</b> First Middle Last				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1910</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Francis M. Burke.</b>				14. MOTHER'S MAIDEN NAME <b>Francis M. ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-03-8522</b>		17. INFORMANT <b>Joseph Valenza 2658 Miles Ave.</b> Address			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cornary Occlusion</b> DUE TO <b>Chronic Myocarditis &amp; AORTIC STENOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>5m ill -</b> <b>No ticard</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>M.B. Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M.B. DAVIS M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 9, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western.</b>		22d. LOCATION (City, town, or county) (State) <b>Edmonson Ave, Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Chenoweth Jr.</b>				ADDRESS <b>3615-17 Chestnut Ave.</b>		24a. REC'D BY REGISTRAR <b>Ms Edith Hurley</b>	
				DATE		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed the certificate, using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar after to burial, cremation, or removal.

BUREAU V. S.

APR 10 1950

RECEIVED

3700

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN 1b <b>76 Days</b>		d. STREET ADDRESS <b>926 N. Calvert Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>M.</b> Last <b>CAMPBELL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <b>KK</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-14-81</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE CAMPBELL</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>218-28-1268</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 22, 1956</b> , to <b>April 7, 1956</b> , that I last saw the deceased on <b>April 7, 1956</b> , and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>JOHN A. SURMONTE</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>4/7/56</b>	
PHYSICIAN'S NAME (Type) <b>JOHN A. SURMONTE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	22b. DATE THEREOF <b>4-9-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WILMINGTON, DELAWARE</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM COOK-BLIGHT INC. FUNERAL HOME</b> <b>6000 HARFORD ROAD, BALTIMORE, MD</b>		24a. REC'D BY REGISTRAR DATE <b>APR 10 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Lawson L. Furbey</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03652 33  
Reg. Dist. No.

3701

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Upperco</u>		c. LENGTH OF STAY IN 1b <u>5-yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>S</u> Middle <u>C</u> Last <u>CAPE</u>				4. DATE OF DEATH <u>April 22</u> Month <u>22</u> Day <u>1956</u> Year			
5. SEX <u>H</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31-1884</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Stemes</u>				14. MOTHER'S MAIDEN NAME <u>Julia Rouer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>John W Cape - Hampstead Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertrophic arthritis</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1-45</u> to <u>4-22-56</u> , that I last saw the deceased alive on <u>4-22-56</u> , 19 <u>56</u> , and that death occurred at <u>7 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G Saffell</u>		M.D. <u>—</u>		ADDRESS (Street, city or town, state) <u>Bersters town Md</u>		DATE SIGNED <u>4-24-56</u>	
PHYSICIAN'S NAME (Type) <u>James G Saffell MD</u>		<u>Bersters town, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Calverton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Tipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>4-24-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

BUREAU V. L.

APR 1 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
3653 3653 41											
Items 8, 9: G177 film 5/15/56L CERTIFICATE OF DEATH											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>SAME</u> b. COUNTY <u>AS</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>					c. LENGTH OF STAY IN 1b <u>24 YRS.</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 CENTRE AVE</u>					d. STREET ADDRESS <u>I.</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LEGNOWSKI</u> Last <u>CARRICK</u>					4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>56</u> 19						
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1893</u> <u>4-10-15/1898</u>		9. AGE (In years last birthday) <u>63</u> yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNK.</u>					
13. FATHER'S NAME <u>WM. LEGNOWSKI</u>					14. MOTHER'S MAIDEN NAME <u>KATHARINE UNK.</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONIE</u>		17. INFORMANT Address <u>PETER CARRICK, SR. — SAME</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4-29-56 DUE TO (b) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Several yrs.</u> <u>Several yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> P. M. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>5/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/29</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>J. Blath</u>					ADDRESS (Street, city or town, state) <u>454 Eastern Ave. Essex md.</u> DATE SIGNED <u>5/2/56</u>						
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-1-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO CO., MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley, Dundalk, Md</u>					24. REC'D BY REGISTRAR <u>Wm. Kelly</u>						
ADDRESS					DATE						

MEDICAL CERTIFICATION

BURDET V. S.

MAY 7 1906

RECEIVED



3702

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2120 Firethorn Road</b>				d. STREET ADDRESS <b>2120 Firethorn Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>HILDA</b> Last <b>CHENOWETH</b>				4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 6, 1894</b>	
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Gumpman</b>				14. MOTHER'S MAIDEN NAME <b>Katherine E. Otto</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>--</b>		17. INFORMANT Address <b>Mrs. Catherine Overbeck, 202 Woodvale Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION, ACUTE</b> <b>4:20 P.M.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>5 YRS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>11 HRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN</b> , 19 <b>55</b> , to <b>APRIL</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>APRIL 27</b> , 19 <b>56</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1437 FUSELAGE AVE, BALTO 20, Md 4/27/56</b>							
ACTUAL SIGNATURE <b>Louis Semenovoff</b>				PHYSICIAN'S NAME (Type) <b>LOUIS SEMENOFF M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/30/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery, Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Inc</b>				ADDRESS <b>1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>MAY 1 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LIBRARY V. S.

1900-1901

3703

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2125 St. Lukes Lane</u>		d. STREET ADDRESS <u>2125 St. Lukes Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Emma Augusta Clary</u>		4. DATE OF DEATH <u>April 8</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1868</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9c. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Janna Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. La Rue Deuber</u>		Address <u>3655 Howard Park Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardiovascular Dis.</u> DUE TO (c) <u>17 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizelus Carcinoma of Chest wall &amp; Metast.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> 19 <u>31</u> , to <u>April 8</u> 19 <u>56</u> , that I last saw the deceased alive on <u>April 7</u> 19 <u>56</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joshua H. Armacost</u> M.D.		ADDRESS (Street, city or town, state) <u>6419 WINDSOR MILL Rd</u>	
PHYSICIAN'S NAME (Type) <u>JOSHUA H. ARMACOST</u>		DATE SIGNED <u>4/8/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Fred'k. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens &amp; Sons - Balto 17</u>		24a. REC'D BY REGISTRAR <u>Mr Wm. E. Martinez</u>	
ADDRESS <u>BALTIMORE 7 Md</u>		DATE <u>11 1956</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03657

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bundabell</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lundabell</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>3208 N. Shoreway</u>		e. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>B</u> Last <u>Cleaver</u>				4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Ret</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John B. Cleaver</u>				14. MOTHER'S MAIDEN NAME <u>Don't Know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>213-10-7321</u>		17. INFORMANT Address <u>M. D. Davis (Home 3208) N. Shoreway</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>A-S-C-V. Disease</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>  </u>			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> or while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4/27/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried April 30 1956</u>		22b. DATE THEREOF <u>April 30 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkridge, Md</u>		22d. LOCATION (City, town, or county) (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. F. H. H. 2112 Lundabell Co</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>  </u>	
24b. REGISTRAR'S SIGNATURE <u>William M. Kelly</u>				DATE <u>4/28/56</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be signed by the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. DEPARTMENT OF AGRICULTURE

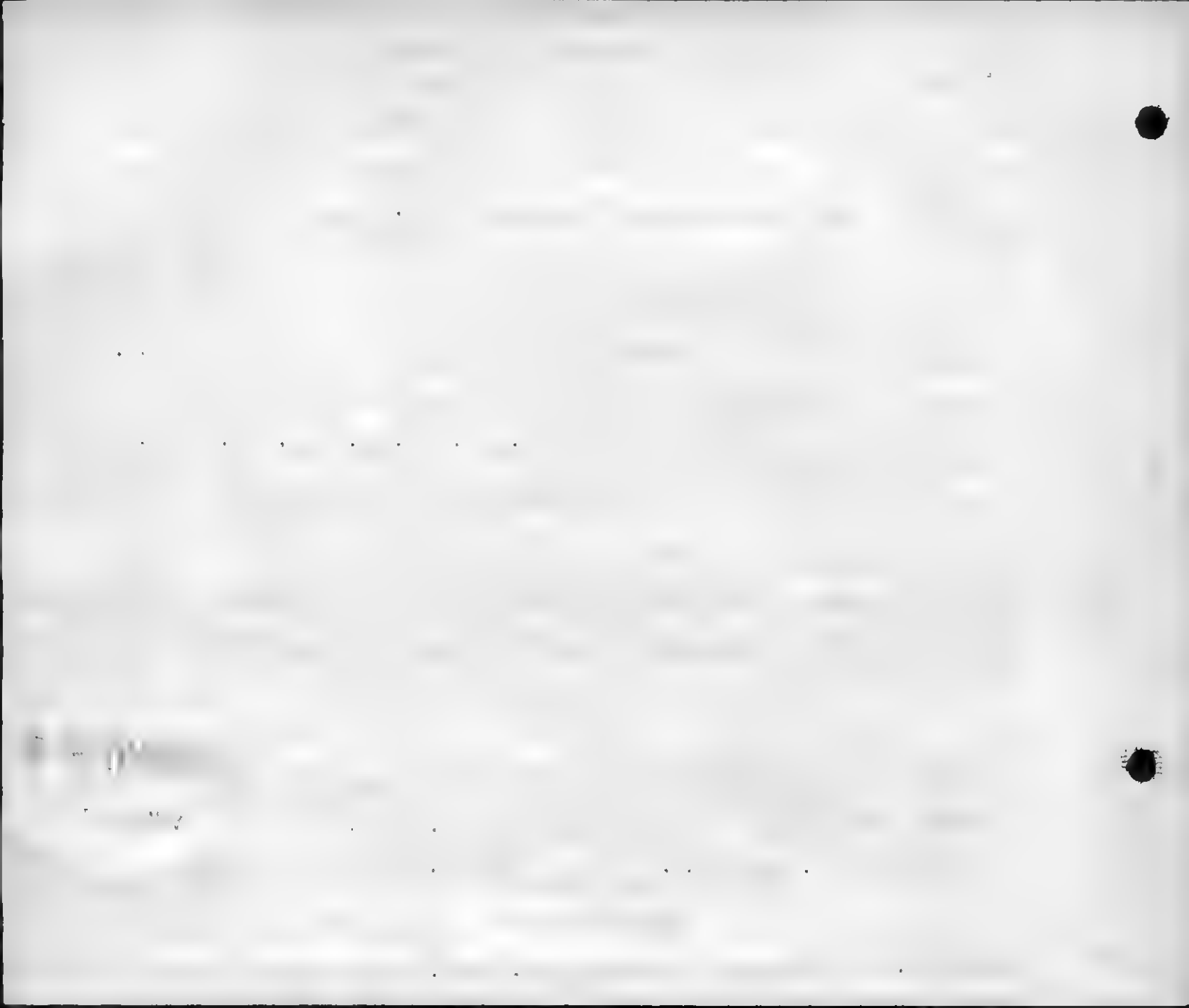
OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

3704

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>37 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>760 W. Franklin St.</b>			
3. NAME OF DECEASED (Type or print) First <b>ALONZO</b> Middle <b>(NMT)</b> Last <b>COATES (COSTES)</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>10</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1896</b>	9. AGE (In years lost birthday) <b>59</b> yrs		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Dublin, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Coates (Costes)</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VASCULAR NEPHRITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>March 4, 1956</b> , to <b>April 10, 1956</b> , and that death occurred at <b>12:20 A.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				M.D. <b>VAH Ft. Howard, Md</b>		DATE SIGNED <b>4/11/56</b>	
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>				VAH Ft. Howard, Md		4/11/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/13/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>				ADDRESS <b>Charles R. Law Mortuary 802-04 Madison Ave. Balto., Md</b>		24a. REC'D BY REGISTRAR <b>Apr. 14-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. P. Fisher</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 3705 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>1 Day 11 Hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3321 Chestnut Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>J.</b> Last <b>COLLISON</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/19/25</b>	
9. AGE (In years last birthday) <b>30</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Calvert Oil Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13. FATHER'S NAME <b>Roland Collison</b>				14. MOTHER'S MAIDEN NAME <b>Anna Alber</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-II</b>				16. SOCIAL SECURITY NO. <b>217 16 6599</b>			
17. INFORMANT <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GLIOMA RIGHT CEREBRAL HEMISPHERE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 27</b> , 19 <b>56</b> , to <b>April 28</b> , 19 <b>56</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>4/29/56</b>							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				M.D. <b>VAH, Fort Howard, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-3-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>David Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight Inc.</b> ADDRESS <b>6009 Harford Rd.</b>				24a. REC'D BY REGISTRAR <b>DATE 7-1956</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3706  
CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) o. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>5-2-55</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM HENRY COOKE JR</b>		4. DATE OF DEATH Month <b>4</b> Day <b>1</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-2-05</b>
9. AGE (In years last birthday) <b>50</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECTION-MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEWART CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HENRY COOKE SR</b>		14. MOTHER'S MAIDEN NAME <b>ELISABETH BECK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-01-0287</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Mt. Wilson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FAR ADVANCED PULMONARY TUBERCULOSIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-3</b> , 19 <b>55</b> to <b>4-1</b> , 19 <b>56</b> ; that I last saw the deceased alive on <b>3-31</b> , 19 <b>56</b> , and that death occurred at <b>7:10 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.			
PHYSICIAN'S NAME (Type) <b>WM. NEWCOMER, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>APRIL 4 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>4430 BEL AIR RD MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Doppel Bldg. 1800 E LOMBARD ST</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
		24b. REGISTRAR'S SIGNATURE <b>Dorothy Russell</b>	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03661

3707

## CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mo. 9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>2 Magnolia Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>O.</b> Last <b>Corey</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> , Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-25-1897</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rigger</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>W. Ship Bldg. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Corey</b>	
14. MOTHER'S MAIDEN NAME <b>Dora ?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>	
16. SOCIAL SECURITY NO. <b>273-81-2699</b>		17. INFORMANT <b>Records Spring Grove State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic interstitial pneumonia, left lung</b> DUE TO (c) <b>Carcinoma apex of right lung (metastatic)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-15</b> , 19 <b>56</b> , to <b>4-24</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-24</b> , 19 <b>56</b> , and that death occurred at <b>12:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachsler</b> M.D. <b>Spring Grove State Hospital</b> <b>4-24-56</b>			
ACTUAL SIGNATURE <b>Stella Wachsler, M. D.</b>			
PHYSICIAN'S NAME (Type) <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>April 27/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ann's</b>		22d. LOCATION (City, town, or county) (State) <b>St. Ann's, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Long</b>		24. REC'D BY REGISTRAR DATE <b>APR 30 1956</b>	
25. REGISTRAR'S SIGNATURE <b>T. E. Barry</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Iter 2, FilmG196 5-1-56

3708

## CERTIFICATE OF DEATH

03662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b				<i>Baltimore 30</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hospital</i>				d. STREET ADDRESS <i>1444 Boyle St.</i>			
3. NAME OF DECEASED (Type or print) <i>ELLA</i> First <i>Louise</i> Middle <i>Craig</i> Last				4. DATE OF DEATH Month <i>4</i> Day <i>29</i> Year <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/6/1880</i>		9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Rice</i>				14. MOTHER'S MAIDEN NAME <i>Mary Craft</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>FAMILY - SAME</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive arteriosclerosis of heart &amp; brain</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <i>General arteriosclerosis</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <i>4/29</i> , 19 <i>56</i> , that I last saw the deceased alive on _____, 19____, and that death occurred at <i>5:30 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Dr. David Kravitz</i> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>5/2/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mount Carmel</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. ...</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>30.9.56</i>	
				24b. REGISTRAR'S SIGNATURE <i>C. ...</i>			

RECEIVED

APR 2

BUREAU U. S.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03663

## 3709 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>COCKEYSVILLE</b>		LENGTH OF STAY (in this place) <b>4 YEARS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>BALTIMORE</b>			
TOWN				STREET ADDRESS (If rural give location) <b>106 S. GILMORE ST</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MASONIC HOME</b>							
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>WILLIAM JOHN CREW</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>4 5 19 56</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>11-1-1859</b>	9. AGE last birthday <b>96</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B+O RR.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM JAMES CREW</b>				14. MOTHER'S MAIDEN NAME <b>SUSANNA AUSTIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S NAME & ADDRESS <b>FRANK L. SMITH, JR COCKEYSVILLE MD</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Arteriosclerosis Cardio Vascular Disease</b>				<b>over 4 yrs</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1952 to April 1956, that I last saw the deceased alive on April 1956, and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
SIGNATURE <b>Walter T. Cook</b>				ADDRESS (Street, city, town, state) <b>Cockeysville Md 5 April 1956</b>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>4-9-56</b>		NAME OF CEMETERY OR CREMATORY <b>Louder Pk</b>		LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Frank Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Inc</b>		ADDRESS <b>1217 St Paul</b>	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS AISC 1-55

RECEIVED

APR 10 1956

03664

3655

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Bolts</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> STREET ADDRESS (If rural give location) <u>216 St Helena Ave</u>			
3. NAME OF DECEASED (First) <u>Sarah</u> (Middle) <u>Crooks</u> (Last) <u>Crooks</u>				4. DATE (Month) <u>April</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Nov 12 1891</u>		9. AGE last birthday <u>64</u> yrs.	10. IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad)		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Parsons</u>				14. MOTHER'S MAIDEN NAME <u>Mary A Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Leroy Crooks 216 St Helena Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
I IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic-Cardio-Vas Dis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Accident</u>				24 hrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>14:30</u>		21e. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 21, 1956</u> , to <u>April 26, 1956</u> , that I last saw the deceased alive on <u>April 24, 1956</u> , and that death occurred at <u>14:30</u> M., from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>removal</u>				24. REC'D BY REGISTRAR DATE <u>4/29/56</u> REGISTRAR'S SIGNATURE <u>William M Kelly</u>			
NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cem</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

37A (100)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3710

## CERTIFICATE OF DEATH

036653w  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr5mth20dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SIRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jean=</b> Middle <b>Pownall</b> Last <b>Curran</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 56</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1884</b>		9. AGE (In years last birthday) <b>71</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Emma Louisa Pownall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>SPRING GROVE STATE HOSPITAL</b>		(County) (State)	
21. I certify that I attended the deceased from <b>July</b> 19 <b>54</b> to <b>April 17, 1956</b> , that I last saw the deceased alive on <b>April 17</b> 19 <b>56</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachler</b> M.D.				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL 4-18-56</b> <b>Catonsville 28, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/20/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cem.</b>		22d. LOCATION (City, town, or county) <b>Riggs Rd. Extd. Hyattsville Pr. Geo. Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. M. Chambers</b>				ADDRESS <b>5801 Cleveland Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE 20 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>P. E. Harry</b>		P.O. Md.	

RECEIVED

1956

RECEIVED

3711

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>66 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>2114 Division Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>CURRY</b> Last <b>CURRY</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 25, 1896</b> 59 yrs
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>	
11. BIRTHPLACE (State or foreign country) <b>White Stone, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Buck Curry</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Harris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>214-14-7034</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>C23X</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SYPHILITIC CARDIOVASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 18 1956</b> to <b>April 24 1956</b> that death occurred on the date stated above. <b>12:40 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>4/25/56</b>			
ACTUAL SIGNATURE <b>Francis G. Dickey</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>FRANCIS G. DICKEY, M.D. Chief, Medical Services VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/30/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NAT'L. CEM. BALTIMORE, MARYLAND</b>	22d. LOCATION (City, town, or county) (State) <b>13</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHARLES G. COOPER -512 CARROLLTON AV.</b>		24a. REC'D BY REGISTRAR <b>APR 27 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Newton L. Farley</b>	

512 N. Carrollton Ave., Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 10 1900  
BUREAU V. S.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3712

## CERTIFICATE OF DEATH

Reg. Dist. No. 03667

Item 13 Film G204 9-70-56

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN Towson				TOWN Towson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 102 Midhurst Rd.				STREET ADDRESS (If rural give location) 102 Midhurst Rd.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DORIS F. DALY				DEATH: April 25, 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	white	Married	May 23, 1917	38 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				N. Y.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Cirus V. Peck				- Boyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
no				no		Mr. Warren B. Daly - 102 Midhurst Rd.	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE							
(A) <i>Myxoma, left atrium</i>							
ANTECEDENT CAUSE (B):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(B) <i>Indurated, chronic, indurated by adenomatous, pleuritic, pericarditis, arthritis, gonorrhea.</i>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 1955 to April 25 1956 that I last saw the deceased alive on April 24, 1956, and that death occurred at 4:15 A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<i>Henry F. Klempfner</i>				M.D. 1101 N. Calvert St. Bldg. 2. 4/25/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		4/25/56		Mt. Hope Cem.		Rochester, N. Y.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
4-25-56		<i>Dr. H. H. H. H.</i>		<i>Chas. J. Pickner</i>		<i>1200 - Baltimore</i>	



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3713

## CERTIFICATE OF DEATH

03668  
44  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>(NMI)</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/93</u>	9. AGE (In years last birthday) <u>63</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat work</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat work</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Shady Side, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Richard Davis</u>				14. MOTHER'S MAIDEN NAME <u>Susan Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-05-2340</u>		17. INFORMANT <u>Clin. Rec. Vets. Adm. Hosp., Fort. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE, RIGHT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12</u> , 19 <u>56</u> , to <u>April 15</u> , 19 <u>56</u> , that I saw the deceased alive on <u>April 12</u> , 19 <u>56</u> , and that death occurred at <u>1:45 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis G. Dickey</u> M.D.				ADDRESS (Street, city or town, state) <u>VAH Fort Howard, Md.</u>		DATE SIGNED <u>4/16/56</u>	
PHYSICIAN'S NAME (Type) <u>FRANCIS G. DICKEY, M.D.</u>				ADDRESS <u>VAH Fort Howard, Md.</u>		DATE SIGNED <u>4/16/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> M				ADDRESS <u>Charles R. Law Mortuary 802 Madison Ave., Balto.</u>		24a. REC'D BY REGISTRAR <u>DATE apr. 19-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

J. A. S.

196

3667

## CERTIFICATE OF DEATH

Reg. Dist. No.

42

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stoma</u>				d. STREET ADDRESS <u>1929 Woodside Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Juliana Maureen Wayhuff</u>				4. DATE OF DEATH <u>April 10 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16 1878</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scrapper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beta Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Wayhuff</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Sauer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-09-9034</u>		17. INFORMANT <u>Patricia Wayhuff</u> Address <u>1929 Woodside Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Colon</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> DUE TO (c) <u>                    </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 - 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1949</u> to <u>April 10 1956</u> , that I last saw the deceased alive on <u>April 10 1956</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William S. Parson</u> M.D.				ADDRESS (Street, city or town, state) <u>1711 Selma Ave Balto-27 Md</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM S. PARSON</u>				DATE SIGNED <u>1711 Selma Ave Balto-27 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Snow Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. Miland Wayhuff Wingard, M.D.</u> ADDRESS <u>                    </u>				24a. REC'D BY REGISTRAR <u>                    </u> DATE <u>                    </u>		24b. REGISTRAR'S SIGNATURE <u>                    </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in payment within 72 hours after death.

U.S. AIR FORCE

APR 1 1960

7-11-60

03670

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3714

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Home Harlem Lane</u>		STREET ADDRESS (If rural, give location) <u>100 E. Cross St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>DECK</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>5</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/10/1889</u>
9. AGE last birthday <u>67</u> yrs.		10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Fritz</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Kriestle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr. Charles Deck 100 E. Cross St.</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
447x Immediate cause (a) <u>Pulmonary Edema</u>		<u>8 hrs</u>
Antecedent cause(s) (b) <u>1 1/2 pulmonary &amp; Arteriosclerosis</u>		<u>unknown</u>
(c) <u>Rt. Hemiplegia</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 11, 1952, to Apr 5, 1956, that I last saw the deceased alive on 4/5, 1956, and that death occurred at 1:12 P.M., from the causes and on the date stated above.

SIGNATURE C. F. Denny (Degree or title) ADDRESS 4605 Edmondson and Baltimore DATE SIGNED 4/6/56

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/9/56</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR ADDRESS <u>JOHN F. DENNY, INC. 715 Light St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3715

## CERTIFICATE OF DEATH

03671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Milford Gardens</b>		c. LENGTH OF STAY IN 1b <b>3 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3412 Mayfair Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Milford Gardens</b>	
3. NAME OF DECEASED (Type or print) First <b>Lillie K.</b> Middle <b>Depser</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 56.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1875</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Herbold</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dietz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>John R. Herbold</b>		Address <b>3412 Mayfair Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>30 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 17, 1956</b> to <b>4/17, 1956</b> that I last saw the deceased alive on <b>4/17, 1956</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. L. Pierpont</b>		DATE SIGNED <b>April 18, 1956</b>	
PHYSICIAN'S NAME (Type) <b>E. L. Pierpont</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-21-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Howard Strong</b>		24a. REC'D BY REGISTRAR DATE <b>Dr. J. M. E. Martin</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3716

## CERTIFICATE OF DEATH

Reg. Dist. No. 0367230

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>48 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>628 Aldershot Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frances L. DiBernardo or Bernard</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1907</b>	9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.	IF UNDER 24 HRS Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cambridge Tailoring (Italy)</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>late Vito Laduca</b>				14. MOTHER'S MAIDEN NAME <b>Anna Passalacqua</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215 01 8144</b>			
17. INFORMANT <b>Stephen DiBernardo</b>				Address <b>628 Aldershot Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>204.5</b> DUE TO <b>Acute leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. 11</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb 15</b> , 19 <b>56</b> , to <b>April 15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 14</b> , 19 <b>56</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3101 W Baltimore St, Baltimore, MD 416/56</b> DATE SIGNED <b>4/16/56</b>							
ACTUAL SIGNATURE <b>Richard Gaffey</b>				M.D. <b>3101 W Baltimore St, Baltimore, MD 416/56</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>April 18/56</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry A. Witzke</b>				ADDRESS <b>4101 Edmondson Ave.</b>			
24a. REC'D BY REGISTRAR <b>DATE</b>				24b. REGISTRAR'S SIGNATURE <b>J. E. Harris</b>			

RECEIVED

APR 18 1955

BUREAU V. S.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

VS A15 (4)  
15M 9/55

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6947

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>24 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMANUEL</u> Middle <u>DIAZ</u> Last <u>DIAZ</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/1933</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR: Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Spain</u>		12. CITIZEN OF WHAT COUNTRY? <u>Spain</u> ✓	
13. FATHER'S NAME <u>Joseph Diaz</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Diaz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Spring Grove State Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infectious heart disease</u> DUE TO (c) <u>Branchioectasia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 May</u> 19 <u>56</u> , to <u>24 June</u> 19 <u>56</u> , that I last saw the deceased alive on <u>24 June</u> 19 <u>56</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas P. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u> DATE SIGNED <u>4-25-56</u>	
PHYSICIAN'S NAME (Type) <u>T. GAYNE WILLIAMS</u>		<u>Catonsville, Pa. 25</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Bld. of Mo</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>AUG 7 '57</u>	24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>

MEDICAL CERTIFICATION

THIS CERTIFICATE WAS FORWARDED TO US LATE FROM THE ANATOMY BOARD.

APPARENTLY IT HAD BEEN MISLAID AMONG SOME PAPERS AND IT WAS

JUST FOUND BY A NEW SECRETARY. WE WERE NOT AWARE OF THE DEATH

BECAUSE NO SERVICE WAS REQUIRED. MNB 8/8/57

BUREAU V. S.

106 8 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within ~~24~~ **72** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03673

## 3717 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		STATE <u>Maryland</u> COUNTY <u>Balto</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>	
TOWN <u>Catonville</u>		LENGTH OF STAY (In this place) <u>Life</u>		TOWN <u>Catonville</u>		TOWN <u>Catonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114 Smithwood Ave</u>				STREET ADDRESS (If rural give location) <u>114 Smithwood Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>DANIEL</u> (First) <u>DIEHL</u> (Middle) <u>MANIV</u> (Last)				4. DATE OF DEATH <u>4-6</u> (Month) <u>1956</u> (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>7-6-1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		Months		Hours
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Fredrick Diehlmann</u>				14. MOTHER'S MAIDEN NAME <u>Beckman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Mrs. Cornelis Diehlmann</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 weeks			
IMMEDIATE CAUSE (A) <u>Left heart failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>ASCVD &amp; mitral regurgitation</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Unknown</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-28</u> , 19 <u>53</u> , to <u>4-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-31</u> , 19 <u>56</u> , and that death occurred at <u>1:15 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Stephen Lee Magness</u>				ADDRESS (Street, city, town, state) <u>908 Frederick Rd. Catonsville, Md.</u>		DATE SIGNED <u>4-8-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		DATE THEREOF <u>4/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lonsene Park Cemetery - Balto Co.</u>		LOCATION (City, town, or county) (State) <u>Md.</u>	
24. REC'D BY REGISTRAR <u>T.E. Hargis</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Hable &amp; Son - Catonsville - Md.</u>		ADDRESS	
DATE <u>4/10/56</u>							

31

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

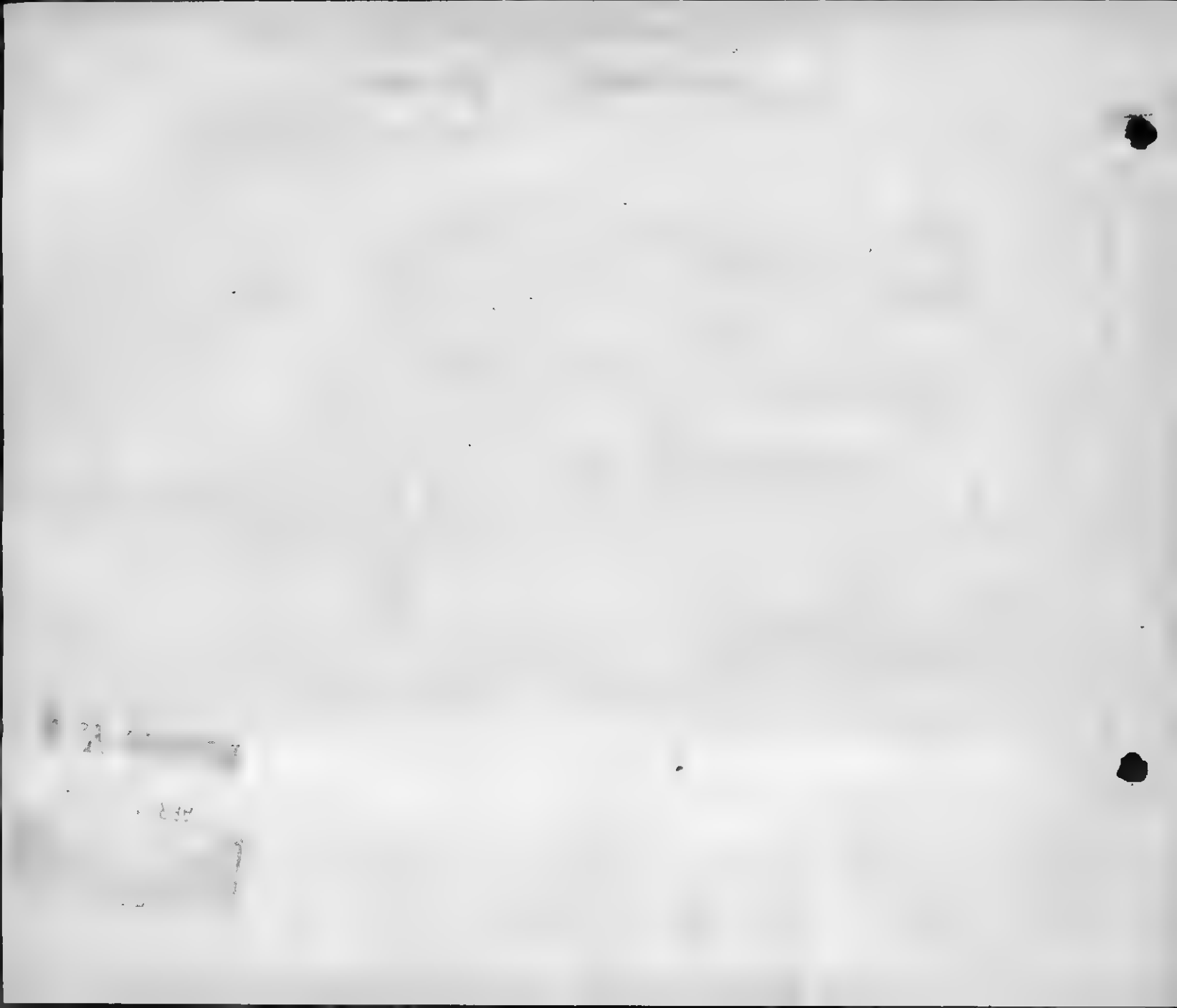
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03674

## 3718 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>DUNDALK 22</u>		<u>9 YRS</u>		TOWN <u>DUNDALK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3129 CORNWALL Rd.</u>				STREET ADDRESS (If rural give location) <u>3129 CORNWALL Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARIAN</u> (Middle) <u>BURKE</u> (Last) <u>DIGGINS</u>				(Month) <u>APR.</u> (Day) <u>10</u> (Year) <u>1952</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>W.H.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 29, 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>SAMUEL BURKE</u>				14. MOTHER'S MAIDEN NAME <u>CATHARINE HILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO REC</u>		17. INFORMANT & ADDRESS <u>C.H. DIGGINS - STATE.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				15 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u> M. <u>—</u> A.		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>M.D. 1125 S. KENNESAW Baltimore Md.</u>		DATE SIGNED <u>APR 13 1952</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APR 13, 1952</u>		NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL CEM.</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR <u>APR 13 1952</u>		REGISTRAR'S SIGNATURE <u>Louise L. Farkes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace Paul Pennington, Md.</u>		ADDRESS <u>—</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03675

3656

## CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9, Filr 0195 4-19-56 et

1. PLACE OF DEATH- Baltimore COUNTY Dundalk		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Dundalk		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore Md	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 York Way		STREET ADDRESS (If rural, give location) Dundalk Md	
3. NAME OF DECEASED (Type or Print) Julia Dolan		4. DATE OF DEATH (Month) 4 (Day) 10 (Year) 19 56	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH II-I-1880 75/76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Ireland
13. FATHER'S NAME Dennis Mc Charty		12. CRIMINAL OR WHAT C S A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Pierre Dolan 15 York Way Dundalk Md	
16. SOCIAL SECURITY No. None		14. MOTHER'S MAIDEN NAME	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a).....

*Suicide*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b).....

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

#### 22. AUTOPSY

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from 4-2, 19 56, to 4-10, 19 56, that I last saw the deceased

alive on 4-10, 19 56, and that death occurred at 1:30 pm, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE/REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

Grand View Cemetery

Johnstown Pa.

24. FUNERAL DIRECTOR

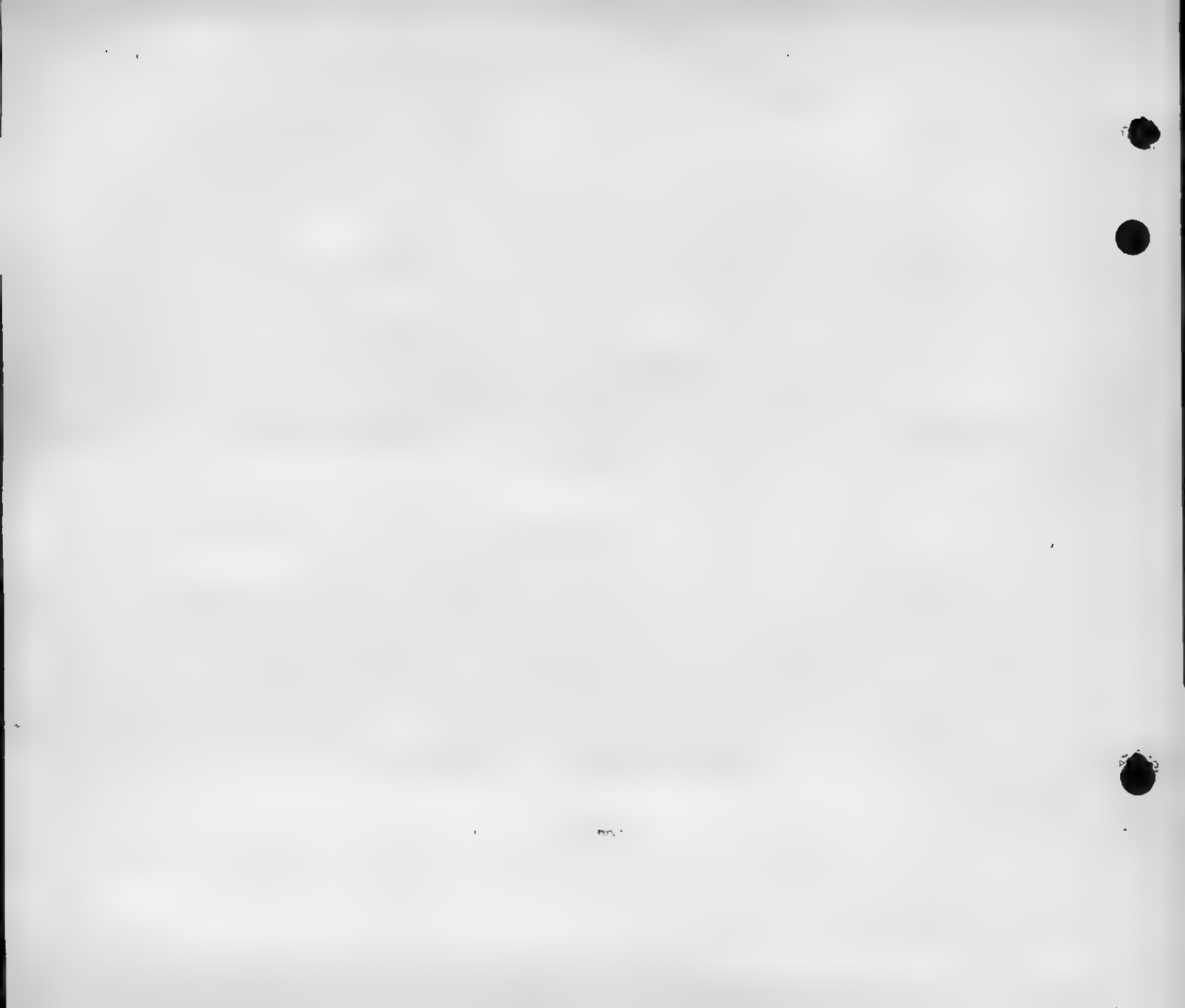
ADDRESS

4/11/56 [Signature] 1001 A Dundalk Ave.

MARGIN RESERVED FOR BINNING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Page 4 of 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3719

## CERTIFICATE OF DEATH

03676 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 Middle River</u>		c. LENGTH OF STAY IN 1b <u>Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Nursing Home</u>		d. STREET ADDRESS <u>Ebenezer Rd. Box 237 Route 16</u>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>E.</u> Last <u>Dougherty</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Martin</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Coyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Margaret Furice-Box 245 Route 16, Zone 20</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis - 10 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 26, 1955, to April 30, 1956</u> , that I last saw the deceased alive on <u>April 28, 1956</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5/1/56</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Harvey L. Fuller</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Harvey L. Fuller</u>		<u>Ridge Road, Baltimore 6, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 3, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Pulaski Rd.</u>	
24a. REC'D BY REGISTRAR <u>5/2/56</u>		DATE <u>Edith Furley</u>	
24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

MAY 3

RECEIVED

3720

## CERTIFICATE OF DEATH

03677

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Catonsville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Balto.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>House in the Pines-Fusting Ave.</b>		STREET ADDRESS (If rural give location) <b>1602 Lochwood Rd.</b>	
3. NAME OF DECEASED (Type or Print) <b>MARGARET C. DOUGHERTY</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 22, 19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>Nov. 5, 1880</b>
9. AGE last birthday <b>75</b> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <b>1 to 2 years</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary Rtd</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Owen Dougherty</b>		14. MOTHER'S MAIDEN NAME <b>Ann Kane</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>712-16-1533</b>	
17. INFORMANT & ADDRESS <b>Mrs. Ann Lynch - 1602 Lochwood Rd.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>422.1 IMMEDIATE CAUSE (A) Arteriosclerotic Degenerative C.V. Disease</b> ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Nephritis with Anemia</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <b>Hypertension. Cirrhosis of Liver.</b> STATING UNDERLYING CAUSE LAST. <b>Severe Secondary Anemia.</b>			<b>1 to 2 years</b>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <b>Sept 9, 19 55</b> , to <b>22 Apr., 19 56</b> , that I last saw the deceased alive on <b>22 Apr., 19 56</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Joseph E. Muse Jr.</b>		ADDRESS (Street, city, town, state) <b>M.D. 5 West 29th St. Balto. 18 Md.</b>	
DATE <b>4/23/56</b>		DATE SIGNED <b>5 West 29th St. Balto. 18 Md.</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		24. REC'D BY REGISTRAR <b>W. E. Harry</b>	
DATE <b>4/23/56</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Vickers &amp; Sons - Balt.</b>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

APR 1 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03678  
403721  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md Balt</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4014 Perry Hall Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E</u> Last <u>Dreyer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 20, 1871</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min. <u>84</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer General</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Himself</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gerhardt Dreyer</u>		14. MOTHER'S MAIDEN NAME <u>Angela Hugelmeyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Paul W. Lacey</u>	
17. INFORMANT <u>Paul W. Lacey</u>		Address <u>4014 Perry Hall Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>arteriosclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>General Arteriosclerosis</u> DUE TO <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 hrs.</u> <u>9 yrs.</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1936</u> to <u>April 29, 1956</u> , that I last saw the deceased alive on <u>April 29, 1956</u> , and that death occurred at <u>4:05 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Fair, Md.</u> DATE SIGNED <u>4/30/56</u> ACTUAL SIGNATURE <u>Clifford F. Hudson</u> PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Stephens Cen</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03679 3722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A. County</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2 yrs. plus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>169 King George Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Erma</b> Middle <b>A.</b> Last <b>Duvall</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-8-1877</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Tydings Henry Q.</b>				14. MOTHER'S MAIDEN NAME <b>Alverda Stallings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hospital Records- Spring Grove</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular Disease</b> (c), stating the underlying cause last, (c) <b>Cardiovascular Disease</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Geo. S.M. Kieffer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>George S.M. Kieffer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<b>April 15, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/15/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>				ADDRESS <b>San Annapolis Md</b>		24a. REC'D BY REGISTRAR DATE <b>4-16-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>P. E. Barry</b>			

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3723

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>?</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catonsville Convalescent Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>1403 Valleyview Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Luntina</u> Middle <u>Etz</u> Last <u>Etz</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ludwig Simokat</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Schaefer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Mrs. Charlotte L. Netzer 1403 Valleyview</u>	
17. INFORMANT <u>Mrs. Charlotte L. Netzer 1403 Valleyview</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration</u> DUE TO <u>Arterio-sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 years</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pernicious Anaemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 20, 1956</u> , to <u>April 24, 1956</u> , that I last saw the deceased alive on <u>April 24, 1956</u> , and that death occurred at <u>10:54 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joshua H. Armacost</u> M.D.		ADDRESS (Street, city or town, state) <u>6419 Windsor Mill Rd Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>JOSHUA H. ARMACOST</u>		DATE SIGNED <u>APR 27 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Avenue</u>	
24a. REC'D BY REGISTRAR <u>APR 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>T. E. Harrys</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 27 1964

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3724

## CERTIFICATE OF DEATH

03681

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD PARK</u>			
c. LENGTH OF STAY IN 1b <u>5 years</u>				d. STREET ADDRESS <u>1742 WENTWORTH RD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1742 WENTWORTH RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>B</u> Last <u>FAMOUS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/20/1900</u>	
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR: Months _____ Days _____		11. IF UNDER 24 HRS: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINISTS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ST. AUTOMOTIVE CO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>PARKER FAMOUS</u>				14. MOTHER'S MAIDEN NAME <u>ROSALIE SWANNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-05-7014</u>		17. INFORMANT <u>Euphemia FAMOUS</u> Address <u>1742 WENTWORTH RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1939</u> , 19____, to <u>4-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-23</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>36 York Court - Baltimore, 18, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>A. L. Ewald, Jr.</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Dr. A. L. Ewald, Jr.,</u> <u>36 York Court</u> <u>Baltimore 18, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-28-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. F. EVANS &amp; SON</u>				ADDRESS <u>8802 HARFORD RD.</u>		24a. REC'D BY REGISTRAR <u>APR 27 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 27 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03682

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

3725

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale md. #7</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home (As in #2)</u>				d. STREET ADDRESS <u>3619 Clifmar Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Ella L. Farmer</u>				4. DATE OF DEATH <u>April</u> Month <u>24</u> Day <u>1956</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 19/1866</u>	
9. AGE (In years last birthday) <u>89</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Norfolk Vir.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Francis H. Beachum</u>				14. MOTHER'S MAIDEN NAME <u>Annie Kohn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Nellie H. Stanig</u> Address <u>3619 Clifmar Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. disease - Chronic</u> DUE TO (c) <u>Coronary Heart Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days -</u> <u>10 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY - 1</u> , 1953, to <u>APRIL 24</u> , 1956, that I last saw the deceased alive on <u>APRIL 24</u> , 1956, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D.				ADDRESS (Street, city or town, state) <u>3601 Clifmar Rd - Balt 7</u> DATE SIGNED <u>4/25/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Mt. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>New Kent Co. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Herwig Sons</u>				ADDRESS <u>2024 Orleans St. Balto. 31 md.</u>		24a. REC'D BY REGISTRAR <u>Dr. Wm. Martin</u>	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BUREAU V. A.

APR 28 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

03683

3726 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERSReg. Dist. No. 39

Item 8 filed 095 1-16-56 at

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u> LENGTH OF STAY (in this place) <u>20 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #1 Box 34</u>		STREET ADDRESS (If rural, give location) <u>Box #34 RFD #1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frederick</u> (Middle) <u>Dan</u> (Last) <u>Flemke</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 2 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lift operator - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Quarry</u>	9. AGE last birthday <u>1889, 66 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Family Records</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion, occlusion</u>		<u>Sudden</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.

SIGNATURE (Degree or title) Charles F. O'Donnell M.D. ADDRESS 2501 York Rd Towson 4md Md. DATE SIGNED 4/5/56

1. DATE OF OPERATION (Specify) Burial DATE THEREOF Apr. 4, 1956 NAME OF CEMETERY OR CREMATORY Fairview Methodist Cem. LOCATION (City, town, or county) (State) Sunnybrook, Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRY 4/5/56 REGISTRAR'S SIGNATURE M. Elizabeth Gorsuch 24. FUNERAL DIRECTOR John Byrne's Sons, Towson, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU A 3

APR 10 1950

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03684

3727

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Liberty Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Ann</u> Last <u>Flynn</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>George W. Frank</u>		14. MOTHER'S MAIDEN NAME <u>Kathreine Kroger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Charles L. Flynn, Liberty Rd., Randallstown</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Periculous Aneurysm, Cerebral</u> <u>422.2</u> DUE TO <u>hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular Disease</u> (c) <u>Cardio-Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>4/21/1956</u> , that I last saw the deceased alive on <u>4/21/1956</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm E. Martin</u>		ADDRESS (Street, city or town, state) <u>Randallstown Md</u>	
PHYSICIAN'S NAME (Type) <u>Wm E. Martin</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 24, '56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>	22d. LOCATION (City, town, or county) (State) <u>Harrisonville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell, Libby</u>		24a. REC'D BY REGISTRAR DATE <u>4/22/56</u>	24b. REGISTRAR'S SIGNATURE <u>Wm E. Martin</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03685

3728

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>206 S. Eden St.</u> STREET ADDRESS (If rural, give location) <u>Baltimore, Md.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Lucie A. Fritz</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4/12/56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/25/88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>67</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Matlock</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>--</u>	
17. INFORMANT AND ADDRESS <u>Mr. Wm. Murray 1229 Patapsco St.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>GASTRIC 1st MALIGNANCY</u> Antecedent cause(s) (b) <u>CANCER of STOMACH</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Anemia secondary to b</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>unknown</u> <u>unknown</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>not volunteered</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/12, 1956</u> , to <u>4/12, 1956</u> , that I last saw the deceased alive on <u>4/11, 1956</u> , and that death occurred at <u>2:25</u> p.m., from the causes and on the date stated above. SIGNATURE: <u>Cliff Kasper</u> (Degree or title) ADDRESS <u>4603 Edmonson Ave</u> DATE SIGNED <u>4/13/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/16/56</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>JOHN F. DENNY, INC. 715 Light St.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03686
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 49
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3488 McShane Way</b>					d. STREET ADDRESS <b>3488 McShane Way</b>					
3. NAME OF DECEASED (Type or print) First <b>Bernice</b> Middle <b>T</b> Last <b>Froeman</b>					4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1956</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1911</b>		9. AGE (In years last birthday) <b>44</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Johns Hopkins Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>George Schaefer</b>					14. MOTHER'S MAIDEN NAME <b>Carrie</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Leonard G. Froeman 3488 Mc Shane Way.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hematoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Paul F. Guerin</i> NAME (Type) <b>Paul F. Guerin, M.D.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>April 7, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Parkville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>					24a. REC'D BY REGISTRAR DATE <b>12-1-56</b>		24b. REGISTRAR'S SIGNATURE <i>John P. Kelly</i>			

EMILY V. J.

"R"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: When this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03687

3729

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>Baltimore County Home</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A</b> Last <b>Fryfogel</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> , Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 14 - 1871</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown FARMER</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown John Fryfogel</b>		14. MOTHER'S MAIDEN NAME <b>Unknown MARGARET MILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Records Spring Grove State Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senility</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-27-</b> , <b>1956</b> , to <b>4-26-</b> , <b>1956</b> , that I last saw the deceased alive on <b>4-26-</b> , <b>1956</b> , and that death occurred at <b>2:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b> DATE SIGNED <b>4-26-56</b>			
ACTUAL SIGNATURE <b>Stella Wachsler</b> M.D.		PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b> <b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-28-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignace</b>		22d. LOCATION (City, town, or county) (State) <b>St. Ignace, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robt. C. B. Walters</b>		24a. REC'D BY REGISTRAR <b>APR 30 1956</b>	
ADDRESS <b>Pratt + Strickland</b>		24b. REGISTRAR'S SIGNATURE <b>V. E. Harry</b>	

BUREAU V. S.

APR 30 1956

RECEIVED

## 3730 CERTIFICATE OF DEATH

Reg. Dist. No. ....

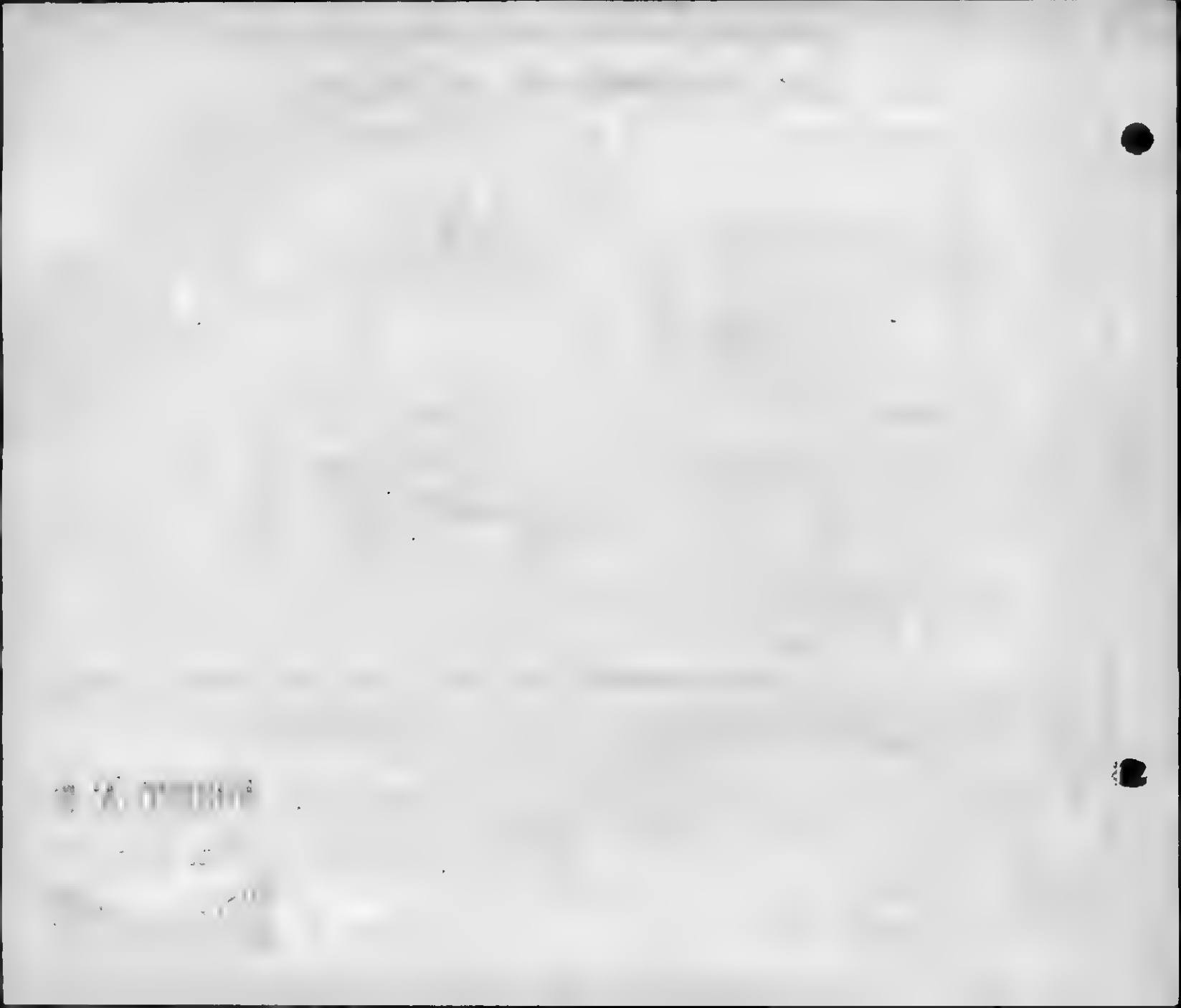
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>Md</u> COUNTY <u>BALTIMORE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY OR TOWN <u>CATONSVILLE</u>	
CITY OR TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (in this place) <u>5 yrs.</u>		STREET ADDRESS <u>606 COLERAINE Rd.</u>		STREET ADDRESS (If rural give location) <u>606 COLERAINE Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Michael Joseph Garaghty, Sr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 2, 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 4, 1904</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Municipal</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael J. Garaghty</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. REILLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mary A. Garaghty 606 COLERAINE Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary Fibrosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>12.1.45</u> , 19____, to <u>4.2.56</u> , 19____, that I last saw the deceased alive on <u>4.2.56</u> , 19____, and that death occurred at <u>9:50 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Nathan Rausin</u>				ADDRESS (Street, city, town, state) <u>M.D. 206 S. Gilmore St</u>			
				DATE SIGNED <u>4.3.56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BY BURIAL</u>		DATE THEREOF <u>April 5, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City, town, or county) <u>BALTIMORE, Md.</u>	
24. REC'D BY REGISTRAR <u>PR 5 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwab</u>		ADDRESS <u>2101 Frederick Ave. Balt. Md.</u>	

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03689

## 3731 CERTIFICATE OF DEATH

Reg. Dist. No. 44

Item #1 - Filed 4-12-56 - mnd.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL or end give nearest town) DUNDALK		LENGTH OF STAY (in this place) 16 Yrs		CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Carrolls Nurseing Home				STREET ADDRESS (If rural give location) 14 Southship Road			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Joseph Thomas Gehr				April 9 19 56			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Nov, 2, 1873	
				9. AGE last birthday 82 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Gehr				14. MOTHER'S MAIDEN NAME Sarah Berry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 202-03-8058		17. INFORMANT & ADDRESS Mrs H. Benge Simmons, Perryville, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Arterio-Sclerotic Cardio-Vas. Dis - 10 yrs							
ANTECEDENT CAUSE(S) (B) Senility & Mental Changes							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Self-imposed Starvation -							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH				21105 -			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 20, 1956, to April 9, 1956, that I last saw the deceased alive on April 2, 1956, and that death occurred at 9:15 A.M. from the causes and on the date stated above.							
SIGNATURE M. B. Davis M.D.				ADDRESS (Street, city, town, state) M.D. 6800 Morningstar Rd - Dundalk - Md. 4/9/56			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 4-12-1956		NAME OF CEMETERY OR CREMATORY Asbury		LOCATION (City, town, or county) Port Deposit, Md. Rural	
24. REC'D BY REGISTRAR DATE 4/12/56		REGISTRAR'S SIGNATURE Dawson L. Farley		25. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		ADDRESS	

MONDAY A

APR



3732

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>2 yr. 8 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove Hospital</b>		e. STREET ADDRESS <b>39 N. Potomac St.</b>	
3. NAME OF DECEASED (Type or print) <b>Katherine Geisendorffer</b>		4. DATE OF DEATH <b>4-20-56</b> 19	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-1873</b> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Bach</b>		14. MOTHER'S MAIDEN NAME <b>Margare Mierling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT <b>Joseph White</b>		Address <b>35 N. Potomac St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio sclerotic cardiovascular disease</b> (c) <b>disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9-12-53</b> 19 to <b>4-20-56</b> 19, that I last saw the deceased alive on <b>4-20-56</b> 19, and that death occurred at <b>11:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel Edwards MD</b>		ADDRESS (Street, city or town, state) <b>Spring Grove Hospital</b> DATE SIGNED <b>4-20-56</b>	
PHYSICIAN'S NAME (Type) <b>DAVID EDWARDS MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 24, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b> <i>per Mary M. Moran</i>		ADDRESS <b>3000 E. Baltimore St.</b>	24a. REC'D BY REGISTRAR <b>U. E. Henry</b> DATE <b>4-20-56</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 24 1951  
STANDARD & S

3733

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore Co.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Towson</u> TOWN <u>3 yrs. 2 mo. 19 da.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sheppard and Enoch Pratt Hosp. Towson 4, Maryland</u>				STATE <u>Maryland</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u> TOWN _____ STREET ADDRESS (If rural give location) <u>4303 Liberty Heights Avenue</u>			
3. NAME OF DECEASED: (First) <u>Sophie</u> (Middle) <u>Louise</u> (Last) <u>Geisz</u>				4. DATE OF DEATH: (Month) <u>April</u> (Day) <u>18</u> (Year) <u>1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct. 16, 1870</u>	
9. AGE last birthday: <u>85</u> yrs.		10. MONTHS: _____		11. DAYS: _____		12. HOURS: _____	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: _____			
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME: <u>Louis Bode</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: _____			
17. INFORMANT & ADDRESS: <u>Hospital Records</u>							

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Broncho pneumonia</u>	DUE TO	<u>Term</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Chronic myocarditis</u>	DUE TO	<u>5 yrs +</u>
(c) <u>Generalized arteriosclerosis</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile psychosis</u>		
19a. DATE OF OPERATION: _____	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

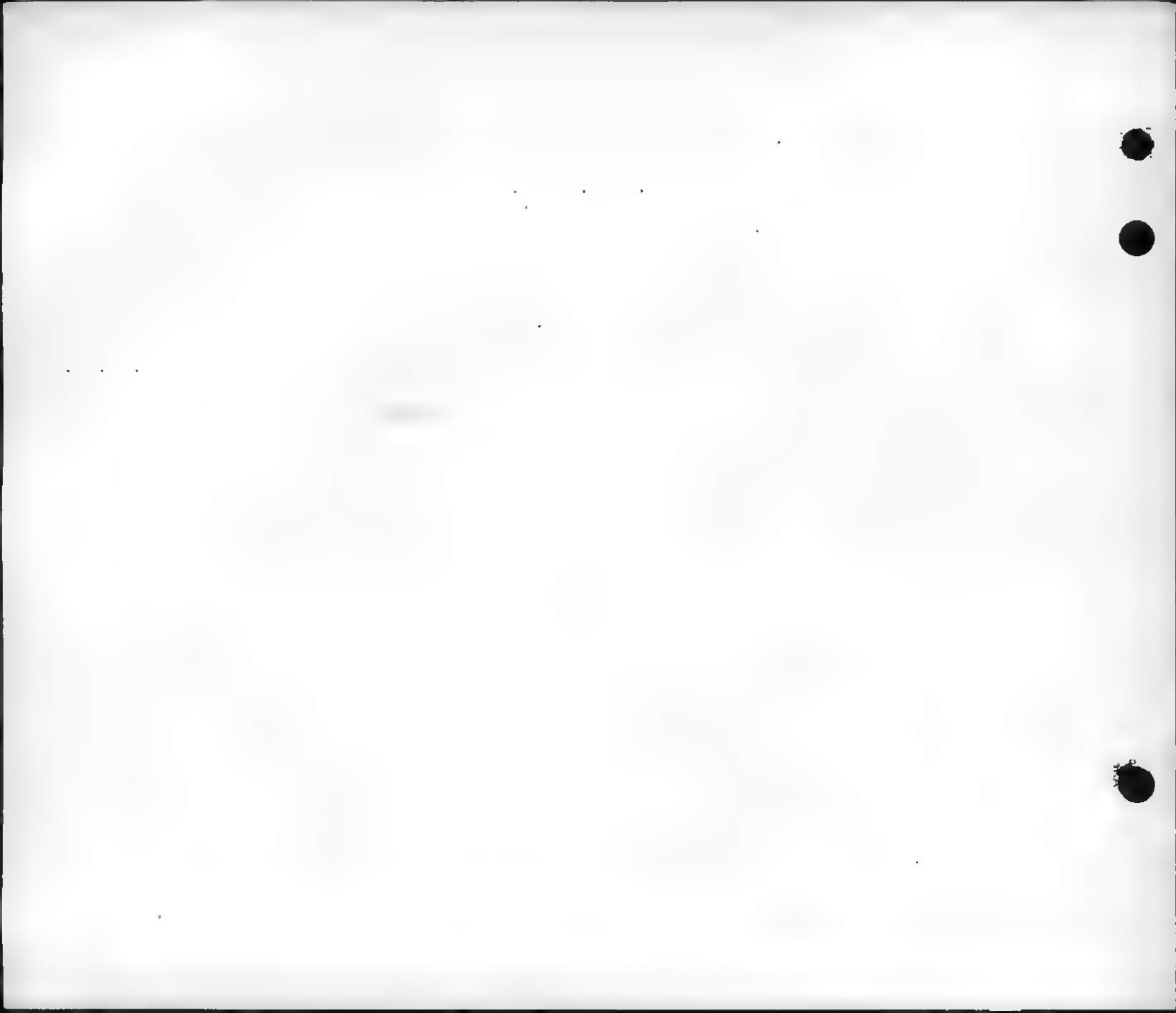
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY _____ m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 29, 1953, to Apr 18, 1956, that I last saw the deceased alive on Apr 17, 1956, and that death occurred at 8:45 PM from the causes and on the date stated above.

SIGNATURE <u>M. R. Geisz</u>	(Degree or title)	ADDRESS <u>Towson 4 Md.</u>	DATE SIGNED <u>4/19/56</u>
THE SHEPPARD & ENOCH PRATT HOSPITAL			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/21/56</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>April 20, 1956</u>	REGISTRAR'S SIGNATURE <u>U. W. Hedrich</u>	24. FUNERAL DIRECTOR <u>Wm. J. ...</u>	ADDRESS <u>... Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. **03622**

3734

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3Y</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING-GROVE STATE HOSP.</b>		d. STREET ADDRESS <b>1400 HOLLINS ST</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>K.</b> Last <b>GEMMILL</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1869</b>
9. AGE (In years last birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saw-mill operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A. (state not known)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>not known</b>		14. MOTHER'S MAIDEN NAME <b>not known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Frances Gemmill, 417 Whitridge Ave #18</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG. 25, 1955</b> to <b>APR. 28, 1956</b> , that I last saw the deceased alive on <b>APR. 28, 1956</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Spring Grove State Hospital 4/28/1956</b>			
ACTUAL SIGNATURE <b>Jewene E. Shapiro</b> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/1/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Marford Road #14</b>		24a. REC'D BY REGISTRAR DATE <b>5/2/56</b>	
24b. REGISTRAR'S SIGNATURE <b>J. E. Harry</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 2 1956

BUREAU W. S.

03693

3735 **CERTIFICATE OF DEATH**Reg. Dist. No. 3c

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dundalk - 22, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>				STREET ADDRESS <u>7502 Parson Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNIE</u>		(Middle) <u>BEYER</u>		(Last) <u>GREEK</u>		(Month) (Day) (Year) <u>Apr. 5, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Mar. 30, 1893</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Beyer</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>George Greek 7502 Parson Ave. Balto. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Metastatic Ca of lungs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>62 mos</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ca of Esophagus</u>				<u>831</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-3</u> , 19 <u>56</u> , to <u>4-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>56</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above							
SIGNATURE <u>Wilmer H. Gallagher</u>				DATE SIGNED <u>M.D. 6207 Frederick Ave. Balt. 28, Md. 4/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/9/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>APR 12 1956</u>		REGISTRAR'S SIGNATURE <u>M. E. Shroyer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Whitish Funeral Home</u>		ADDRESS <u>Dundalk, Md.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

3 A 100000

100000

100000

100000



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03694

3736

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>New Jersey</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Quinn's Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>East Orange</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D #2 Lyons Mills Rd.</u>		STREET ADDRESS (If rural, give location) <u>91 Franklin St</u>	
3. NAME OF DECEASED (Type or Print) <u>Ellen Dunsmore Griffith</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>April 5</u> 19 <u>56</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 2, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
13. FATHER'S NAME <u>Charles E. Utermohle</u>		12. CITIZEN OF WHAT COUNTRY <u>Baltimore City</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Deohan</u>	
16. SOCIAL SECURITY No. <u>?</u>		17. INFORMANT AND ADDRESS <u>Mrs. Leasie M. Weidman (Quinn's Mills Rd)</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>UREMIA (KIDNEY FAILURE)</u>		
Antecedent cause(s) (b) <u>METASTATIC CARCINOMA</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>CERVICAL CARCINOMA</u>	<u>3 YRS</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1955, to April, 1956, that I last saw the deceased alive on 4-5, 1956, and that death occurred at 3:00 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-7-56</u>	<u>Woodlawn Cemetery</u>	<u>Woodlawn, Baltimore Md.</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 7<sup>th</sup> 1956</u>	<u>R.W.</u>	<u>George J. Ruth Inc</u>	<u>1735 Hanford Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 3737 CERTIFICATE OF DEATH

03695

31

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Woodlawn		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Woodlawn			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5814 Gwynn Oak Ave.				STREET ADDRESS (If rural give location) 5814 Gwynn Oak Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) LETITIA (Middle) (Last) GRISWOLD				(Month) (Day) (Year) Apr. 23, 19 56			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Jan. 4, 1865	9. AGE last birthday 91 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Moore				14. MOTHER'S MAIDEN NAME Catherine Ritter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Miss Lillian Griswold-5814 Gwynn Oak Av			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				Infirmity of age			
ANTECEDENT CAUSE(S) DUE TO (B)				Fractured hip			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Generalized Arteriosclerosis			
19. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.) HOME		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) 5814 Gwynn Oak Ave. Md.		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Prior to death M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Slipped & fell to floor			
22. I hereby certify that I attended the deceased from March 19 56, to April 23 19 56, that I last saw the deceased alive on 4-23, 19 56, and that death occurred at 4 PM, from the causes and on the date stated above.							
SIGNATURE Wm. H. Abbott				ADDRESS (Street, city, town, state) 4509 Liberty Hwy. Lk. Ave. Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/26/56		NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		LOCATION (City, town, or county) (State) Pikesville, Md.	
24. REC'D BY REGISTRAR APR 25 1956		REGISTRAR'S SIGNATURE Dr. Wm. E. Martin		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Trebner & Sons		ADDRESS Baltimore 17 Md.	

BUREAU V. A.

APR 26 1956

RECEIVED V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3738 CERTIFICATE OF DEATH

03696  
Reg. Dist. No. 21

1. PLACE OF DEATH o COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GORDON AVE</u>		d. STREET ADDRESS <u>6236 GORDON AVE</u>	
3. NAME OF DECEASED (Type or print) <u>ROY SWANSON HALE</u>		4. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/21/02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u>	9. AGE (In years last birthday) <u>54</u> yrs
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELBERT HALE</u>		14. MOTHER'S MAIDEN NAME <u>ELEN HACKLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>21212-0330</u>	
17. INFORMANT <u>WIFE Katherine HALE</u>		Address <u>6623 Lynne Ave Woodlawn, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>THROMBOPHLEBITIS</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JANUARY 1950</u> to <u>APRIL 27 1956</u> , that I last saw the deceased alive on <u>APRIL 26 1956</u> , and that death occurred at <u>4:35 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edwin J. Hargrave</u> M.D.		DATE SIGNED <u>8024 LIBERTY RD BALTO MD 6/12/56</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN J. HARGRAVE</u>		ADDRESS (Street, city or town, state) <u>8024 LIBERTY RD BALTO MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial April 30, 1956</u>	22b. DATE THEREOF <u>April 30, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Terrence Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		ADDRESS <u>Pikesville</u>	
24a. REC'D BY REGISTRAR <u>APR 30 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Jm. E. Martin</u>	

BUNNELL V. B.

OR 7-1-1900

RECEIVED

3739

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL, LENGTH OF STAY  
 OR and give nearest town)  
 TOWN Rural: Towson (in this place)  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Eudowood Sanatorium  
Towson, Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Pratto  
 CITY (If outside corporate limits, write RURAL, and give nearest town)  
 OR  
 TOWN Towson, Md.  
 STREET ADDRESS (If rural give location)  
510 Delaware Ave.

## 3. NAME OF DECEASED:

(First) John (Middle) Russell (Last) Hall  
 (Type or Print)

## 4. DATE OF DEATH:

(Month) 4 (Day) 23 (Year) 1956

## 5. SEX:

M

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

WIDOWED

## 8. DATE OF BIRTH:

4-30-74

## 9. AGE last birthday: IF UNDER 1 YEAR

81 yrs.Months 0 Days 0Hours 0 Min. 0

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

WIREMAN

## 10b. KIND OF BUSINESS OR INDUSTRY:

Electric Co.

## 11. BIRTHPLACE (State or foreign country):

Baltimore, Md

## 12. CITIZEN OF WHAT COUNTRY:

U.S.

## 13. FATHER'S NAME:

WilliamHall

## 14. MOTHER'S MAIDEN NAME:

Mary A. Mattee

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

no

## 16. SOCIAL SECURITY NO.:

(If Yes, give war or dates of service)

## 17. INFORMANT &amp; ADDRESS:

Personal History  
Hospital Records, Eudowood Sanatorium

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Pulmonary Tuberculosis.  
DUE TO

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

15 yrs

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-2, 1942, to 4-23, 1956, that I last saw the deceased alive on 4-22, 1956, and that death occurred at 6:20 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

## DATE THEREOF

April 25, 1956

## NAME OF CEMETERY OR CREMATORY

PROSPECT HILL CEM.

## LOCATION (City, town, or county)

TOWSON, MD.

## (State)

DATE REC'D BY LOCAL REGISTRAR

April 27, 1956

REGISTRAR'S SIGNATURE

Mabel C. Gray

24. FUNERAL DIRECTOR

John Burne' Stone, Towson, Md.

ADDRESS

Towson, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

WORLD V. S.

1956

0310



3740

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Howard</b>		c. LENGTH OF STAY IN lb <b>371 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>HALL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 22, 1890</b>
9. AGE (In years last birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min <b>65</b>	11. IF UNDER 24 HRS. Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min <b>65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Supper Club</b>	
11. BIRTHPLACE (State or foreign country) <b>Cincinnati, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Hall</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth - MN: Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>219-32-0718</b>	
17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COR PULMONALE</b> DUE TO <b>PULMONARY EMPHYSEMA AND ASTHMATIC BRONCHITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEART DISEASE</b> (c) <b>HEART DISEASE</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY TUBERCULOSIS, OLD MYOCARDIAL INFARCTION, 3. ARTERIOSCLEROTIC HEART DISEASE.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 12</b> , 19 <b>55</b> , to <b>April 17</b> , 19 <b>56</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francis G. Dickey</b>		DATE SIGNED <b>4/18/56</b>	
PHYSICIAN'S NAME (Type) <b>FRANCIS G. DICKEY, M.D., Chief Medical Service, VAH, FT. HOWARD, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/21/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Anne Arundel County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard C. Fleming</b>		24a. REC'D BY REGISTRAR <b>April 20 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>L. L. Larkins</b>			

VS A15 (4)  
15M 9/55

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A 00000

1000000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## 3741 CERTIFICATE OF DEATH

03699

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rock Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>		STREET ADDRESS (If rural, give location) ADDRESS <u>-----</u>	
3. NAME OF DECEASED (Type or Print) <u>Sarah Ada Harrison</u>		4. DATE OF DEATH <u>April 20 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 15, 1900</u>
9. AGE last birthday <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Doney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-10-56</u>	
17. INFORMANT AND ADDRESS <u>Samuel J. Harrison Rock Hall, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral thrombosis, multiple</u>		<u>1 month</u>	
Antecedent cause(s) (b) <u>Arteriosclerotic cardiovascular is</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes mellitus</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 7, 1956</u> , to <u>April 29, 1956</u> , that I last saw the deceased alive on <u>April 29, 1956</u> , and that death occurred at <u>3:30 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE: <u>Robert L. Lickas, M.D.</u>		ADDRESS: <u>705 East Drive Baltimore, Md.</u>	
DATE SIGNED: <u>4/29/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF: <u>4/29/56</u>	
NAME OF CEMETERY OR CREMATORY: <u>Wesley Chapel</u>		LOCATION (City, town, or county) (State): <u>Rock Hall Md</u>	
24. FUNERAL DIRECTOR: <u>Edgar L. Lane</u>		ADDRESS: <u>Church Hill</u>	
DATE REC'D BY LOCAL REG. <u>4/29/56</u>		REGISTRAR'S SIGNATURE: <u>Samuel J. Harrison</u>	

BUREAU V. S.

JAY 2 1956

RECEIVED

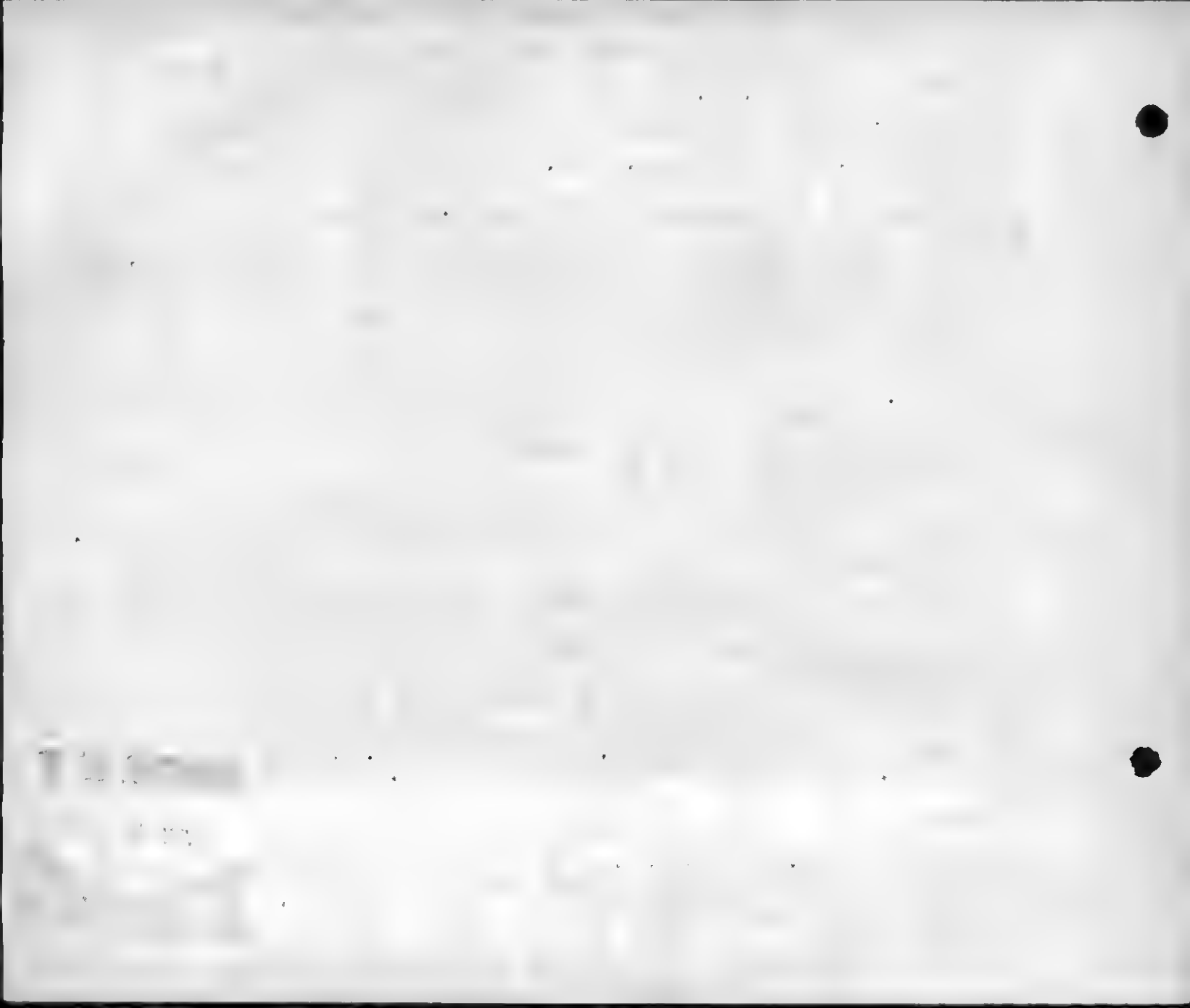
3742

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 23, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>135 S. Warwick Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Heinz</u> Last <u>Heinz</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/53</u>
9. AGE (In years last birthday) <u>2</u> yrs		IF UNDER 1 YEAR Months <u>4</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Frank F. Kahrs</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Heinz (Miss)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Hydrocephalus with recent Meningitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial Pneumonia complicated with</u> DUE TO (c) <u>Varicella</u>			INTERVAL BETWEEN ONSET AND DEATH <u>since birth</u> <u>48 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 22, 1954</u> to <u>Apr. 2, 1956</u> , that I last saw the deceased alive on <u>Apr. 1, 1956</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carlos E. Arrabal</u>		ADDRESS (Street, city or town, state) <u>2980 N. Calvert ST. 11/2/56</u>	
PHYSICIAN'S NAME (Type) <u>Carlos E. Arrabal, M.D.</u>		DATE SIGNED <u>11/2/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>4/3/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. [unclear] Sons, L. I.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

1900 Eutaw Place

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3743 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03702

Reg. Dist. No. 45

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harewood Park</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harewood Park, P.R.R. Crossing</b>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ford</b> Middle <b>Ray</b> Last <b>Helmick, Jr.</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>16</b> Year <b>1956</b>													
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 26, 1944</b>		<b>9. AGE</b> (In years last birthday) <b>12</b> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Schoolboy</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Webster Springs, W.Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>									
<b>13. FATHER'S NAME</b> <b>Ford Ray Helmick, Sr.</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ora Dye</b>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Ford Ray Helmick, Sr.</b> <span style="float: right;">Address <b>Chase 20, Md.</b></span>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound Fracture of skull</b> 802x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractures of all bones of body</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by P.R.R. train</b>													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>5:15</b> p. m. <b>April 16 1956</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Harewood Grocery Store, Chase</b>		<b>20f. (City or town)</b> <b>Baltimore</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> 				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>													
<b>EXAMINER'S NAME (Type)</b> <b>Melvin B. Davis, M.D.</b>				<b>DATE SIGNED</b> <b>4/17/56</b>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>4-19-56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Belair Memorial Garden</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Baltimore</b> (State)											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> 				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>4-19-56</b>				<b>24b. REGISTRAR'S SIGNATURE</b> 									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 18 1956

BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03703  
2c

3744

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook, Rolling Rd.</u>		d. STREET ADDRESS <u>714 McHenry St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>P.</u> Last <u>Henkel</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1883</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Glass Works</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henkel</u>		14. MOTHER'S MAIDEN NAME <u>Bridget O'Holleran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>217-07-2439</u>	
17. INFORMANT <u>J. Norman Henkel</u>		Address <u>701 Charing Cross Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE -</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY EDEMA -</u> DUE TO (c) <u>PNEUMONITIS - PULMONARY EMPHYSEMA</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/1</u> , 19 <u>56</u> , to <u>4/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>56</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 Edmondson Ave. 4/17/56</u> PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 19/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Larry H. Witte</u>		ADDRESS <u>4101 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>R. E. Hays</u>		24b. REGISTRAR'S SIGNATURE <u>R. E. Hays</u>	

BUREAU V. S.

APR 18 1956

RECEIVED

3745

# CERTIFICATE OF DEATH

44

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY		1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Fort Howard		130 days		Baltimore							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Veterans Administration Hospital				1910 Englewood Avenue							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
ELIZABETH		E.		HESS				April		21 1956	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/19/83		72	Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife				Maryland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Charles W. Creek		Sarah Mallott									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes <input checked="" type="checkbox"/> WWI		None		Clin. Rec. Vets. Adm. Fort Howard, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM WITH GENERALIZED METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from December 13, 1955, to April 21, 1956, and that death occurred at 1:00 A.M., from the causes and on the date stated above.											
ACTUAL SIGNATURE		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED					
DONALD D. MARK		M.D.		Fort Howard, Md.							
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)			
Burial		4-24-56		Woodlawn		Woodlawn, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. RECD BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
J.J. Tickner & Sons, Inc., North Ave., Baltimore, Md.				DATE		Dawson L. Fisher					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BUREAU V. S.

APR 24 1962

RECEIVED  
FBI

037064

3746

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft. Howard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>5122 Franklintown Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>C.</u> Last <u>HESSLER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 20, 1886</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>56</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Jacob Hessler</u>				14. MOTHER'S MAIDEN NAME <u>Annie LaRoach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>215-09-1170</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE COMMON BILE DUCT WITH METASTASIS</u> <u>155 X</u> DUE TO <u>TO THE LIVER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January 7, 1956</u> , to <u>April 6, 1956</u> , that he died on <u>April 6, 1956</u> and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. DATE OF DEATH <u>April 6, 1956</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>4/6/56</u>							
ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D. <u>VAH Ft. Howard, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK</u>				<u>VAH Ft. Howard, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-9-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook - Blight, Inc</u> ADDRESS <u>6009 Harford Road, Baltimore, Md</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Newton L. Farley</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. For this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR MAIL

APR 10 1956

RECEIVED

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **30**

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>BALTIMORE</b>		STATE <b>MD</b>		COUNTY			
CITY OR TOWN <b>CATONSVILLE</b>		LENGTH OF STAY (in this place) <b>1 yr</b>		CITY OR TOWN <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>RIDGEWAY MANOR</b>		STREET ADDRESS (if rural give location) <b>2210 GALLOWAY AVE.</b>					
3. NAME OF DECEASED (Type or Print) <b>ISIAH HEYMAN</b>				4. DATE OF DEATH <b>4-27-56</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED <b>WIDOWED</b>		8. DATE OF BIRTH <b>85</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GROCEER</b>		11. BIRTHPLACE (State or foreign country) <b>LATVIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>YEHESKAH</b>				14. MOTHER'S MAIDEN NAME <b>NRHAMA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>ISER HEYMAN - SAME</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <b>Cerebrovascular accident</b>				<b>1 week</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Coronary Arteriosclerosis</b>				<b>2 yrs</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept 1955</b> to <b>April 27, 1956</b> , that I last saw the deceased alive on <b>April 26, 1956</b> , and that death occurred at <b>3:25 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>J. Wilson McKay</b>		ADDRESS (Street, city, town, state) <b>M.D. 6014 EDWARDS AVE CATONSVILLE MD.</b>		DATE SIGNED <b>4/27/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>4-29-56</b>		NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>		LOCATION (City, town, or county) (State) <b>Balto, Md</b>	
24. REC'D BY REGISTRAR <b>MAY 1 1956</b>		REGISTRAR'S SIGNATURE <b>F. E. Harry</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc</b>		ADDRESS <b>2100 Eutaw Pl</b>	

3747

Wc. 03707

5. 1/2

3. 1/2



## CERTIFICATE OF DEATH

Reg. Dist. No. 0370831

3748

Item 9, Film 31, 47, 10, 20, 20, 20

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GWYN OAK</b>		c. LENGTH OF STAY IN 1b <b>11 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AUGSBURG HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO MD</b>	
		f. STREET ADDRESS <b>605 E 33<sup>rd</sup> St.</b>	
3. NAME OF DECEASED (Type or print) <b>Rica</b> First <b>HOFFMAN</b> Middle <b>HOFFMAN</b> Last		4. DATE OF DEATH <b>4/7/56</b> Month <b>4</b> Day <b>7</b> Year <b>19 56</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15/1873</b> (In years last birthday) <b>2 56</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN HOFFMAN</b>		14. MOTHER'S MAIDEN NAME <b>AMELIA CARMER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>RECORDED AUGSBURG HOME</b>	
17. INFORMANT <b>RECORDED AUGSBURG HOME</b> Address <b>CAMPFIELD RD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple Chronic Infections Arthritis</b> DUE TO (c) <b>Generalized Arterio-Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>- 8 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 31, 1950</b> , to <b>April 7, 1956</b> , that I last saw the deceased alive on <b>April 5, 1956</b> , and that death occurred at <b>4:35 P. M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Earl L. Chambers</b> M.D.		ADDRESS (Street, city or town, state) <b>4108 Liberty St. - Balto Md</b> DATE SIGNED <b>4-7-56</b>	
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/9/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>12<sup>th</sup> United Co. Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul G. Klemm</b> ADDRESS <b>6067 Hayford Rd</b>		24a. REG'D BY REGISTRAR <b>APR 11 1956</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Dr. J. W. C. Martin</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUENOS A. S.

APR 11

RECEIVED

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Md</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN lb <b>3 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4402 Alan Drive</b>				d. STREET ADDRESS <b>4402 Alan Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Bella Hooper</b>		First <b>Bella</b>		Middle <b>Hooper</b>		Last	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>Dec. 4, 1886</b>		8. DATE OF BIRTH <b>Dec. 4, 1886</b>	
9. AGE (In years last birthday) <b>69 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sect</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. Steel Co.</b>	
13. FATHER'S NAME <b>Judson V. Hooper</b>				14. MOTHER'S MAIDEN NAME <b>Mary B. Blair</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>4402 Alan Drive</b>		17. INFORMANT <b>Juddie H. Layman</b>		Address <b>4402 Alan Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>481X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Snipple</b> DUE TO (c) <b>3 minutes</b> <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 minutes</b> <b>3 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/26</b> , 19 <b>54</b> , to <b>4/16</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/16</b> , 19 <b>56</b> , and that death occurred at <b>2 p. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert A. Reiter</b>		ADDRESS (Street, city or town, state) <b>3408 Windsor Ave Baltimore - 16, Md</b>					
PHYSICIAN'S NAME (Type) <b>Robert A. Reiter, M.D.</b>		DATE SIGNED <b>4/16/56</b>					
22a. BURIAL, CREMATION, REBURYAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-20-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		22d. LOCATION (City, town, or county) (State) <b>Roanoke, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
						24b. REGISTRAR'S SIGNATURE <b>Dr. M. H. H. H.</b>	

BUREAU V. S.

APR 18 1952

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3749

## CERTIFICATE OF DEATH

03710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 15 <u>172 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle <u>D.</u> Last <u>HUBBS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 24, 1917</u>	9. AGE (In years last birthday) <u>39</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Floor Covering</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wesley Hubbs</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Begerly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>217-09-1309</u>		17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LIP WITH METASTASIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GASTRIC ULCER, BLEEDING</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 5, 1955</u> , to <u>April 25, 1956</u> , that he was the deceased alive on <u>November 5, 1955</u> , and that death occurred at <u>8:30 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>4/2/56</u>							
ACTUAL SIGNATURE _____ M.D. <u>VAH, FORT HOWARD, MARYLAND</u>							
PHYSICIAN'S NAME (Type) <u>JOSEPH M. MILLER, M.D. Chief, Surgical Service VAH, FORT HOWARD, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight Inc</u> <u>Wm Cook-Blight, Inc, 6009 Harford Rd., Balto. 1, Md</u>				24a. REC'D BY REGISTRAR <u>May 7 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Larson &amp; Larfen</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

BUREAU V. 8

1950

RECEIVED

3750

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY Baltimore Co.

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

Towson2 yr. 8 mo. 20 da.HOSPITAL OR INSTITUTION OR STREET ADDRESS Sheppard & Enoch Pratt Hosp., Towson 4, Md.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY Balto.

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

Baltimore

STREET ADDRESS (If rural give location)

Wiseberg, Ba Co Maryland

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

MauriceHunter

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

4211956

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

Male

white

single

Apr. 21, 188274

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

signal operator

10b. KIND OF BUSINESS OR INDUSTRY:

Railroad

11. BIRTHPLACE (State or foreign country):

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Silas W. Hunter

## 14. MOTHER'S MAIDEN NAME:

Sarah Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.

17. INFORMANT &amp; ADDRESS:

Hospital Records

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) DUE TO

Broncho pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

Chronic myocarditis

(c) DUE TO

Generalized arteriosclerosis

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Chronic Brain Syndrome due to Cerebral arterio-sclerosis

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

Interval Between Onset And Death

Term.4 yr +4 yr +4 yr +

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 11, 1953 to April 21, 1956 that I last saw the deceasedalive on April 20, 1956 and that death occurred at 8:15 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M. Elgme MDTHE SHEPPARD & ENOCH PRATT HOSPITAL Towson, Md4/21/56

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIALApr. 24, 1956Evon. Lutheran cem.Shrawsbury, Pa.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 24, 1956Mabel C. GrayJohn Burne Sore, Towson, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD V. S.



3751

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03712

30

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				e. STREET ADDRESS <b>Caton Ridge Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Irwin</b> Middle <b>Iglehart</b> Last <b>Iglehart</b>				4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Unknown</b>	
9. AGE (In years last birthday) <b>73?</b> yrs.		IF UNDER 1 YEAR Months <b>73?</b> Days <b>73?</b> Hours <b>73?</b> Min. <b>73?</b>		IF UNDER 24 HRS. Hours <b>73?</b> Min. <b>73?</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records Spring Grove State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Dehydration</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture of right pubis at junction of horizontal ramus and descending ramus and fracture of rt. ischium</b> <b>Unknown — Found on admission to hospital</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE INJURY OR TORTURE <b>Unknown — Found on admission to hospital</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Unknown</b> p. m. <b>Unknown</b> 19 <b>56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Unknown</b>		20f. (City or town) (County) (State) <b>Unknown</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>George S. M. Kieffer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George S. M. Kieffer, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/5/56</b>		22b. DATE THEREOF <b>4/5/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christ of Good Hope School Baltimore, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS <b>APR 24 1956</b>			
				24a. REC'D BY REGISTRAR <b>V. E. Arroyo</b>			
				24b. REGISTRAR'S SIGNATURE <b>V. E. Arroyo</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use extension of time certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3669

## CERTIFICATE OF DEATH

Reg. Dist. No.

03713

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heithorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heithorpe</u> 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4511 Rehmann Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>May</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27, 1866</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11 BIRTHPLACE (State or foreign country) <u>Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ireland</u>		14. MOTHER'S MAIDEN NAME <u>Clementine Michel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Mrs. Frank Schulz - 4511 Rehmann Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <u>493x</u> DUE TO <u>Terminal pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Natural Causes</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 3, 1956</u> to <u>April 12, 1956</u> , that I last saw the deceased alive on <u>April 12, 1956</u> , and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Lombardo</u> M.D.		ADDRESS (Street, city or town, state) <u>910 W. Lombard St.</u>	
PHYSICIAN'S NAME (Type) <u>Charles Lombardo</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 16, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Luff</u>	
DATE <u>APR 16 1956</u>			

W. A. DILLON

-R 16 1-

1916

MARYLAND STATE DEPARTMENT OF HEALTH

03714

3752

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HILLSIDE AVE</u>		STREET ADDRESS (If rural, give location) <u>HILLSIDE AVE</u>	
3. NAME OF DECEASED (Type or Print) <u>ROSA</u> (First) <u>MAY</u> (Middle) <u>JACKSON</u> (Last)	4. DATE OF DEATH <u>APRIL 24</u> 19 <u>56</u> (Month) (Day) (Year)		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE <u>MARRIED</u> WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3-7-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE</u>	9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY SMITH</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH YOUNG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>BERTHA JACKSON COCKEYSVILLE</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4</u> Immediate cause (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>		<u>5 YRS</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.

SIGNATURE <u>William A. Pearsbury</u> (Degree or title) <u>M.D.</u>	DATE SIGNED <u>4/24/56</u>
SIGNATURE <u>Timonium</u>	DATE SIGNED <u>4/24/56</u>
DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE <u>26 April 1956</u>	LOCATION (City, town, or county) <u>Cockeysville Md</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S ADDRESS <u>Scott Brooks, Sparks, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR

BUKZAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03715

3753

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>EDGEWATER</u> (19/30 YRS)				OR TOWN <u>AS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Q802 RIVER DRIVE Rd.</u>				STREET ADDRESS <u>#1</u> (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LYDIA MARIA JARVINEN</u>				<u>4-8-1956</u>			
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug. 23, 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>FINLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>FINLAND</u> ✓	
13. FATHER'S NAME <u>AARON CALLIO</u>				14. MOTHER'S MAIDEN NAME <u>HILMAN (ONK)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or k.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>EMIL JARVINEN - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4-8-1 IMMEDIATE CAUSE (A) <u>acute coronary insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension, Ht. disease</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1954</u> to <u>April 1956</u> , that I last saw the deceased alive on <u>4-8</u> , 19 <u>56</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>J. J. Means</u>				ADDRESS (Street, city, town, state) <u>520 D St. Balt 19 Md</u> DATE SIGNED <u>4/9/56</u>			
23. BURIAL, CREMATION, TOWNAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>DAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albion B. ...</u>		ADDRESS	
DATE <u>Apr. 10-56</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M





TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3754

CERTIFICATE OF DEATH

03716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>12 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>3403 Boston Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM S JENKINS</b>		4. DATE OF DEATH Month Day Year <b>APRIL 4 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 30, 1892</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William S. Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Effie May Dean</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>218-12-0704</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, LEFT UPPER LOBE</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 23, 1956</b> , to <b>April 4, 1956</b> , that he was deceased on <b>April 4, 1956</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald D. Mark</b>		ADDRESS (Street, city or town, state) <b>VAH Ft. Howard, Md</b>	
DATE SIGNED <b>4/4/56</b>		DATE SIGNED <b>4/4/56</b>	
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>		ADDRESS <b>VAH, FORT HOWARD, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/6/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b>		ADDRESS <b>6009 Harford Road, Balto. Md</b>	
24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Lawrence L. Farley</b>	

BUREAU V. S.

APR 10 1956

RECEIVED

3658

## CERTIFICATE OF DEATH

Reg. Dist. No. 77

03717

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) Dundalk  
LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 3409 Liberty Parkway

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Balto.  
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) Dundalk

STREET ADDRESS (If rural give location) 3409 Liberty Parkway

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
WILLIAM F. (KAHLERT) KAHLER

4. DATE OF DEATH: (Month) (Day) (Year)  
April 4, 19 56

## 5. SEX:

Male

## 6. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widowed

## 8. DATE OF BIRTH:

Ja. 3, 1871

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

85 yrs. Months Days Hours Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

Watchman-ret.

## 10b. KIND OF BUSINESS OR INDUSTRY:

Germany

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Unknown

## 14. MOTHER'S MAIDEN NAME:

Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
No.

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Mrs. Margaret Kahler, Cambridge Arms Apts,

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

DUE TO

Congestive Heart Disease

Interval Between Onset And Death

2 days

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

Arteriosclerosis, generalized

4 years

(c)

Diabetes Mellitus

4 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Diabetic gangrene with bilateral amputation

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

## INJURY OCCURED

While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 19 55 to 4 April, 1956, that I last saw the deceased alive on 3 April, 1956, and that death occurred at 11 A.M. 4 April 1956, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Morris Rainess, M.D.

2900 Dunbar Rd. Balto. 22

5 April 56

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

April 7-1956 William M Kelly

Ullrich Funeral Home 2112 Dundalk Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 10 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3755

## CERTIFICATE OF DEATH

03718

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hospital</u>		d. STREET ADDRESS <u>Delchester Road</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MAE</u> Last <u>KERGER</u>		4. DATE OF DEATH April 2 19 56	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 4 1886</u>
9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHIRT MFG</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H. CHAFFMAN</u>		14. MOTHER'S MAIDEN NAME <u>LENA PARKS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Henry Kerger</u>	
17. INFORMANT <u>Delchester Road</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Senility &amp; Secondary Severe Dehydration &amp; Malnutrition</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>52</u> , to <u>4/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/2</u> , 19 <u>56</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph R Cowen</u> M.D.		DATE SIGNED <u>4/2/56</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH R. COWEN</u>		<u>SPRING GROVE HOSPITAL</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/5/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, CATONSVILLE, MD.</u>		24a. REC'D BY REGISTRAR <u>4/3/56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>J.E. Harry</u>	

BUREAU V. S.

APR 4 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3756 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03719

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPARKS Pt-19</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rheem Mfg. Co Dispensary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William H. Kinzer</b> <div style="text-align: center; font-size: small;">First Middle Last</div>		4. DATE OF DEATH <div style="text-align: center;">Month Day Year <b>April 26 1956</b></div>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30-1914</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY <b>Rheems Manfact. Co. Orange, Va.</b>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <b>Kinzer</b>	
14. MOTHER'S MAIDEN NAME <b>Not Known</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Mildred L. Kinzer</b> Address <b>1219 N. Montford Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>430.1</b> DUE TO  Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cardio-Vascular Disease</b> (c) <b>Disease</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M.B. DAVIS M.D.</b>		DATE SIGNED <b>4/27/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 30-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Miller</b>		ADDRESS <b>2334 Jefferson St.</b>	
24a. REC'D BY REGISTRAR <b>APR 30 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Lark</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 20 1900

RECEIVED



3757

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>1</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 28</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove Hospital</i>		e. STREET ADDRESS <i>4305 Wilkens Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>HELEN</i> Middle <i>WALSH</i> Last <i>KIRWAN</i>		4. DATE OF DEATH Month <i>4</i> Day <i>24</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-22-1885</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Walsh</i>		14. MOTHER'S MAIDEN NAME <i>Helen Goodrich</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-28-3795 B</i>	
17. INFORMANT <i>Mr. Albert N. Kirwan - 4305 Wilkens Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiac Disease</i> <i>4-22-1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Parkinson Disease &amp; Arthritis</i> INTERVAL BETWEEN ONSET AND DEATH <i>15</i> <i>error</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-23-1956</i> to <i>4-24-1956</i> , that I last saw the deceased alive on <i>4-24-56</i> 12, and that death occurred at <i>7:45 p.m.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Rena Becker</i> M.D. <i>Spring Grove Hospital - Catonsville 28</i> PHYSICIAN'S NAME (Type) <i>RENA BECKER MD Catonsville 28 Md. 4-25-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/28/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Dickner &amp; Sons - Balt</i>		24. REG'D BY REGISTRAR <i>W. E. Harry</i>	

BUREAU V. S.

APR 22 1961

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3758

## CERTIFICATE OF DEATH

03721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN IB <u>30 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 Belinda Ave.</u>		d. STREET ADDRESS <u>19 Belinda Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>H.</u> Last <u>Kreager</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1869</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William Rohde</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edward Kreager</u> Address <u>19 Belinda Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>March 27, 1947</u> to <u>April 23, 1956</u> , that I last saw the deceased alive on <u>April 23, 1956</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Adam G. Swiss</u>		ADDRESS (Street, city or town, state) <u>6232 Belair Rd, Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ADAM G SWISS</u>		DATE SIGNED <u>APR. 24, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 26, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>Mr. A. L. Ruffenberger</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. A. L. Ruffenberger</u>	

RECEIVED  
APR 1950  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3759 CERTIFICATE OF DEATH

Reg. Dist. No.

037223

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings Mills, Maryland</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Frederick</u> Last <u>Krieg</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>19 56</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/36</u>
9. AGE (In years last birthday) <u>19</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
11. IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James William Krieg</u>		14. MOTHER'S MAIDEN NAME <u>Anna Leona Connelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>000-00-0000</u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u>Rosewood St. Tr. School, Owings Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd Ventricular tumor with internal hydrocephalus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>and cessation of respiration.</u> DUE TO (c) <u>Lung edema, failure of heart.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u> <u>Tuberculous Sclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tuberculous Sclerosis with symptomatic Epilepsy</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that I attended the deceased from <u>August 20, 19 56</u> , to <u>April 8, 19 56</u> , that I last saw the deceased alive on <u>April 8, 19 56</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry B. Butler</u> M.D.		ADDRESS (Street, city or town, state) <u>Rosewood St. Tr. School, Owings Mills, Md.</u>	
DATE SIGNED <u>4/10/56</u>		DATE SIGNED <u>4/10/56</u>	
PHYSICIAN'S NAME (Type) <u>Harry B. Butler, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Rosewood St. Tr. School, Owings Mills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 10/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline, Sons Restriction</u>		24a. REC'D BY REGISTRAR <u>DATE 4-10-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24c. REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	

372

9501

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03723

3760 **CERTIFICATE OF DEATH**

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Baltimore Zone 7</u>		<u>8 YRS.</u>		TOWN <u>Baltimore Zone 7</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5619 Carroll Ave</u>				STREET ADDRESS (If rural give location) <u>5619 Carroll Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>GEORGE</u> (Middle) <u>KRUG</u> (Last) <u>Sr.</u>				(Month) <u>April</u> (Day) <u>24</u> (Year) <u>1956</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Male</u>		<u>White</u>		<u>Widower</u>		<u>Jan. 11, 1878</u>	
<b>9. AGE last birthday</b>		<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>	
<u>78 yrs.</u>		<u>Machinist Continental Can Co.</u>		<u>Maryland</u>		<u>U. S. A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Frederick Krug</u>				<u>UNKNOWN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>215-02-2678</u>		<u>Baltimore - 7, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>19. DATE OF OPERATION</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>20. AUTOPSY?</b>			
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary sclerosis; myocardial degeneration</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary sclerosis; myocardial degeneration</u>				<u>5 years</u>			
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<b>21e. HOW DID INJURY OCCUR?</b>		<b>21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21g. HOW DID INJURY OCCUR?</b>			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
<b>22. I hereby certify that I attended the deceased from <u>11-1</u>, 19 <u>51</u>, to <u>4-25</u>, 19 <u>56</u> that I last saw the deceased alive on <u>4-21</u>, 19 <u>56</u>, and that death occurred at <u>3:00</u> A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>Stephen Lee Unpress</u>				<u>Catonsville, 908 Frederick Rd</u>		<u>4-25-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<u>Burial</u>		<u>Apr. 27, 1956</u>		<u>Holy Redeemer Cemetery</u>		<u>Baltimore, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>4/26/56</u>		<u>V.E. Harry</u>		<u>Easton Jones</u>		<u>Catonsville, Md.</u>	

RECEIVED  
APR 1 1964  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

0372420

Reg. Dist. No.

3761

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mo. 28 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>748 McHenry Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN J. KUMMEL</b>		4. DATE OF DEATH Month Day Year <b>April 30, 19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-14-1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Luchtings Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland BALTO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Kummel</b>		14. MOTHER'S MAIDEN NAME <b>Eva Braun</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b>			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-2-</b> , 19 <b>56</b> , to <b>4-30-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-30-</b> , 19 <b>56</b> , and that death occurred at <b>6:11 A.M.</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Daniel Edwards M.D.</b>		ADDRESS (Street, city or town, state) <b>Spring Grove Hospital</b>	
PHYSICIAN'S NAME (Type) <b>David Edwards, M.D.</b>		DATE SIGNED <b>4-30-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/3/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>3801 Frederick Ave</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Cowan</b>		24a. REC'D BY REGISTRAR <b>W. E. Harry</b>	
ADDRESS <b>29 Collins St.</b>		DATE <b>5/1/56</b>	

RECEIVED

MAY 2 1956

BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

3762

CERTIFICATE OF DEATH

18 03725 31  
Reg. Dist. No.

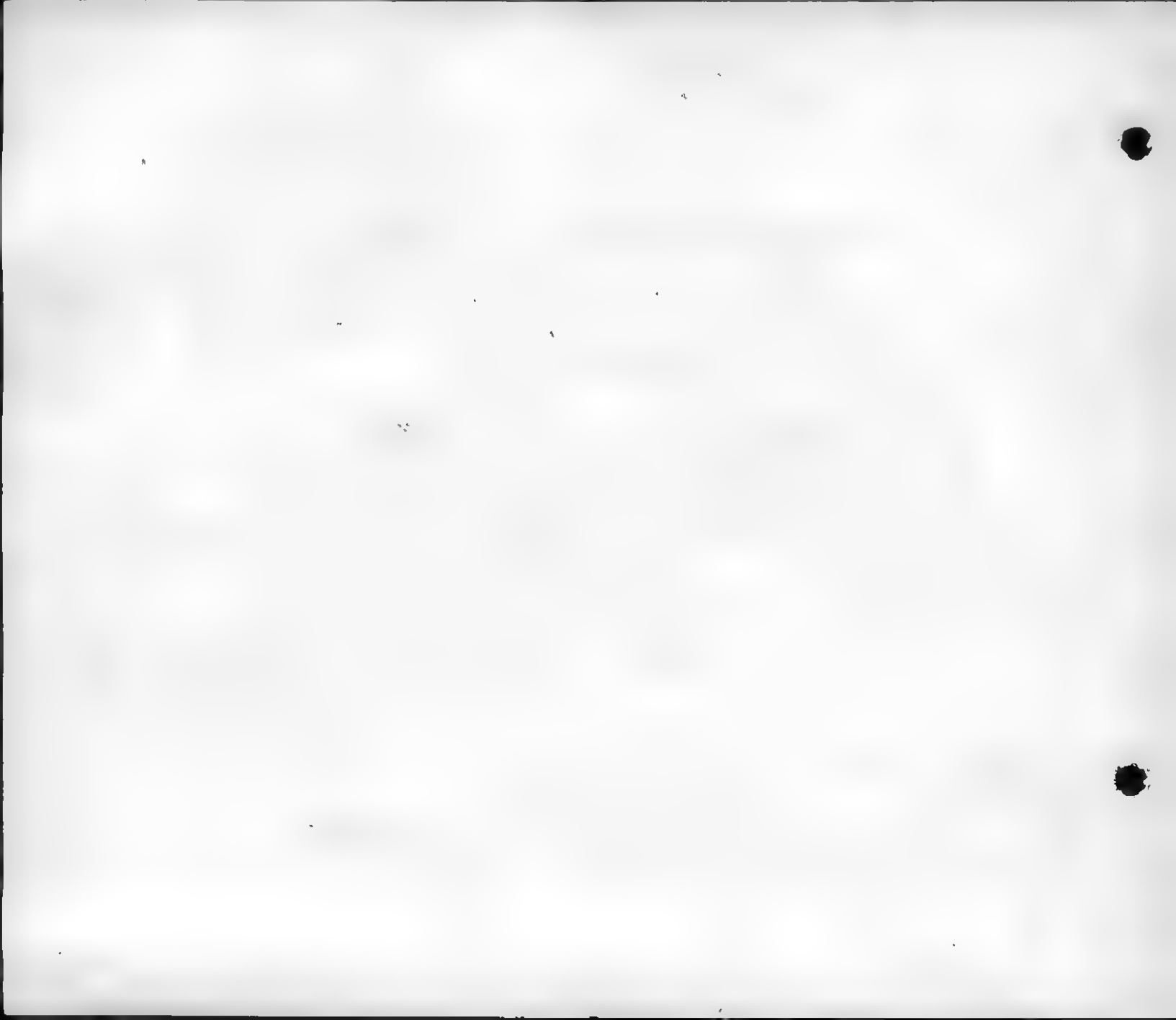
1. PLACE OF DEATH COUNTY <b>BALTIMORE</b> MARYLAND CITY (If outside corporate limits, write RURAL, or give nearest town) <b>RURAL - ROCKDALE</b> LENGTH OF STAY (in this place) <b>8 YEARS</b> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>3524 ST. JAMES Rd.</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b> COUNTY <b>BALTO.</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>RURAL - ROCKDALE</b> STREET ADDRESS (If rural give location) <b>3524 ST. JAMES Rd.</b>	
3. NAME OF DECEASED: (Type or Print) <b>FANNIE CATHERINE LAKE</b> (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH <b>4/6 1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>WIDOWED</b>	8. DATE OF BIRTH: <b>APRIL 1, 1868</b>
9. AGE last birthday <b>88</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>HOUSEWIFE</b>	11. BIRTHPLACE (State or foreign country): <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME: <b>JACOB E. STEEP</b>	
14. MOTHER'S MAIDEN NAME: <b>MARK BARTON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY No. <b>—</b>		17. INFORMANT & ADDRESS: <b>EDWARD WEBER. DAUGHTER - MRS. 3524 ST. JAMES RD, BALTO. 7</b>	

18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>5</b> IMMEDIATE CAUSE (A) <b>CONGESTIVE HEART FAILURE</b> DUE TO ANTECEDENT CAUSE (B) <b>ACUTE BRONCHITIS</b> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS.</b> <b>ONE WEEK.</b>
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19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>FEBRUARY 1950</b> , to <b>APRIL 6, 1956</b> , that I last saw the deceased alive on <b>APRIL 5, 1956</b> , and that death occurred at <b>1:50 A.M.</b> , from the causes and on the date stated above. SIGNATURE <b>Edwin J. Pierpont</b> ADDRESS <b>8204 LIBERTY RD, BALTO. MD.</b> DATE SIGNED <b>4/6/56</b> M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>4-9-1956</b>		NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	
LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>		24. FUNERAL DIRECTOR <b>G. Howard Strong</b>		ADDRESS <b>3207 W. North Ave.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Apr 6 1956</b>		REGISTRAR'S SIGNATURE <b>C. W. Peduch</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3763

## CERTIFICATE OF DEATH

Reg. D. **03726**<sup>30</sup>

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Balto.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5 Catonsville</u>			c. LENGTH OF STAY IN 1b <u>2 1/2 Mo.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1511 Midvale Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mary E. Thompson Lanowitz</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>27</u> Year <u>19 56</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1875</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph Chaney</u>			14. MOTHER'S MAIDEN NAME <u>Emily</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mr. Leroy Thompson, 1511 Midvale Ave</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>June 5, 1944</u> to <u>April 26, 1956</u> , that I last saw the deceased alive on <u>April 26, 1956</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE <u>Carl P. Roetling</u>		M.D. <u>1326 N. Lombard St</u> <u>April 30, 1956</u>			
PHYSICIAN'S NAME (Type) <u>CARL P. ROETLING</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Dorsey Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witte</u>		ADDRESS <u>4101 Edmondson Ave.</u>	24a. REC'D BY REGISTRAR DATE <u>1 1956</u>	24b. REGISTRAR'S SIGNATURE <u>H. E. Harry</u>	

W. A. GARDNER

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W. A. GARDNER

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72-hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3764

## CERTIFICATE OF DEATH

03727  
20

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>8months11days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>1953 W. Fayette Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Isabelle</b> Middle <b>Lawless</b> Last <b>April</b>		4. DATE OF DEATH Month <b>12</b> , Day <b>19</b> , Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-1890</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	11. IF UNDER 24 HRS Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Stephen Campbell</b>	
14. MOTHER'S MAIDEN NAME <b>Hettie &amp; Mary-A. Kane</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records Spring Grove State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-1-1955</b> to <b>4-12-1956</b> that I last saw the deceased alive on <b>4-12-56</b> , and that death occurred at <b>9:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>4-12-56</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/16/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick - Ave</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Conaway</b>		24a. REC'D BY REGISTRAR <b>10-15-56</b>	
ADDRESS <b>55 Collins St.</b>		24b. REGISTRAR'S SIGNATURE <b>J. C. Hays</b>	

RUDDARD V. S.

APR 10

1900



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 3765 CERTIFICATE OF DEATH

03728

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE Md</u>	LENGTH OF STAY (in this place) <u>3 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor Home</u>		STREET ADDRESS (If rural give location) <u>514 S. COLLINS AVE</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>WALTER C. Ledy</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 7 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10/12/1889</u>
9. AGE last birthday <u>66</u> yrs		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward C. Ledy</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HILL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>212-10-4326</u>	
17. INFORMANT & ADDRESS <u>Mrs. Rachel C Ledy</u>		<u>514 S COLLINS AVE.</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) DUE TO ANTECEDENT CAUSE(S) (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		<u>Cardiac Fibrillation</u> <u>Pleurisy &amp; effusion</u> <u>Pneumonia</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <u>60 yrs</u> <u>2 months</u> <u>4 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-15</u> 19 <u>55</u> , to <u>4-7</u> 19 <u>56</u> , that I last saw the deceased alive on <u>4-7</u> 19 <u>56</u> and that death occurred at <u>9:54</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>Walter C. Ledy</u>		ADDRESS (Street, city, town, state) <u>805 Drexel Ave 28 Md</u>	
DATE <u>4-7-56</u>		DATE SIGNED <u>4-7-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/19/56</u>	
NAME OF CEMETERY OR CREMATORY <u>London Park Cem</u>		LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. REC'D BY REGISTRAR <u>V. E. Ledy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Freeman Schwalbe</u>	
DATE <u>4-7-56</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	

BUREAU V. S.

APR 10 1956

RECEIVED

3766

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Run Rd.</b>		d. STREET ADDRESS <b>Western Run Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Adam</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-30-1900</b>
9. AGE (In years last birthday) <b>55</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>methodist church</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George E. Lee</b>		14. MOTHER'S MAIDEN NAME <b>Emma Meyers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-18-9941</b>	
17. INFORMANT <b>Mrs. Madeline Lee, Cockeysville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>hypertension &amp;</b> DUE TO (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-22-56</b> 19, to <b>4-22-56</b> 19, that I last saw the deceased alive on <b>4-22-56</b> 19, and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James B. Raffell M.D.</b>		ADDRESS (Street, city or town, State) <b>Reisterstown, Md</b>	
PHYSICIAN'S NAME (Type) <b>James B. Raffell</b>		DATE SIGNED <b>4-24-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-25-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gough's Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>		ADDRESS <b>Sparks, Md.</b>	
24a. REC'D BY REGISTRAR <b>26 April 56</b>		24b. REGISTRAR'S SIGNATURE <b>Ann Ernestine MacRae</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 27 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03730

3767

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>14 yr 11 mo, 19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				e. STREET ADDRESS <b>2019 East Pratt Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Valeria (Walerja) Lewandowski</b>				4. DATE OF DEATH Month Day Year <b>April 5, 19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-3-1894</b>	9. AGE (In years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records Spring Grove State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Regurgitation of food into bronchus</b> DUE TO (c) <b>Severe Parkinson's Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>15 minutes</b> <b>25 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Inanition</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>7</b> , <b>1953</b> , to <b>4-5</b> , <b>19 56</b> that I last saw the deceased alive on <b>4-5</b> , <b>19 56</b> , and that death occurred at <b>11:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachler</b> M.D. <b>Spring Grove State Hospital</b> <b>4-5-56</b>							
ACTUAL SIGNATURE <b>Stella Wachler</b> M.D. <b>Spring Grove State Hospital</b> <b>4-5-56</b>							
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-9-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Rd., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b> <b>82 Hudson St.</b>				24a. REC'D BY REGISTRAR DATE <b>10 1956</b>		24b. REGISTRAR'S SIGNATURE <b>E. Harris</b>	

RECEIVED

APR 10 1956

BURBANK

03731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 mos. 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1011 MALDEIS ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle (Correct) GEORGE W. LEWIS		4. DATE OF DEATH Month Day Year APRIL 18 1956					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 8, 1886	9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman, Balto. Paint		10b. KIND OF BUSINESS OR INDUSTRY Color Wks.		11. BIRTHPLACE (State or foreign country) Baltimore Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Grant Griffith		14. MOTHER'S MAIDEN NAME Loah Griffith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown		16. SOCIAL SECURITY NO. 214-14-4657A		17. INFORMANT Address Records Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4-6.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suppurative nephritis DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 31, 1956, to Apr. 18, 1956, that I last saw the deceased alive on April 18, 1956, and that death occurred at 11:40 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jerome E. Shapiro M.D.		ADDRESS (Street, city or town, state) Spring Grove State Hosp 4/18/56 DATE SIGNED Catonsville, Md.					
PHYSICIAN'S NAME (Type) Jerome E. Shapiro, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 21, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witske		ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE P. E. Harvey	

EDWARD V. S.

APR

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3670

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Landsdown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Landsdown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4021, York Rd</u>		STREET ADDRESS (If rural, give location) <u>4021 York Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Patty</u> (Middle) <u>Marie</u> (Last) <u>Lindblade</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 26 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH (Month) (Day) (Year) <u>March 17 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>50</u> yrs. If under 1 year: Months Days If under 24 hrs: Hours Min.
13. FATHER'S NAME <u>Richard Lindblade</u>		14. MOTHER'S MAIDEN NAME <u>Patricia MacLeod</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>4-2-111111-1111</u>	
17. INFORMANT AND ADDRESS <u>4021 York Rd</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pneumonia

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Spina-bifida

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 day  
Birth

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/17, 1956, to 4/26, 1956, that I last saw the deceasedalive on 4/12, 1956, and that death occurred at 11:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

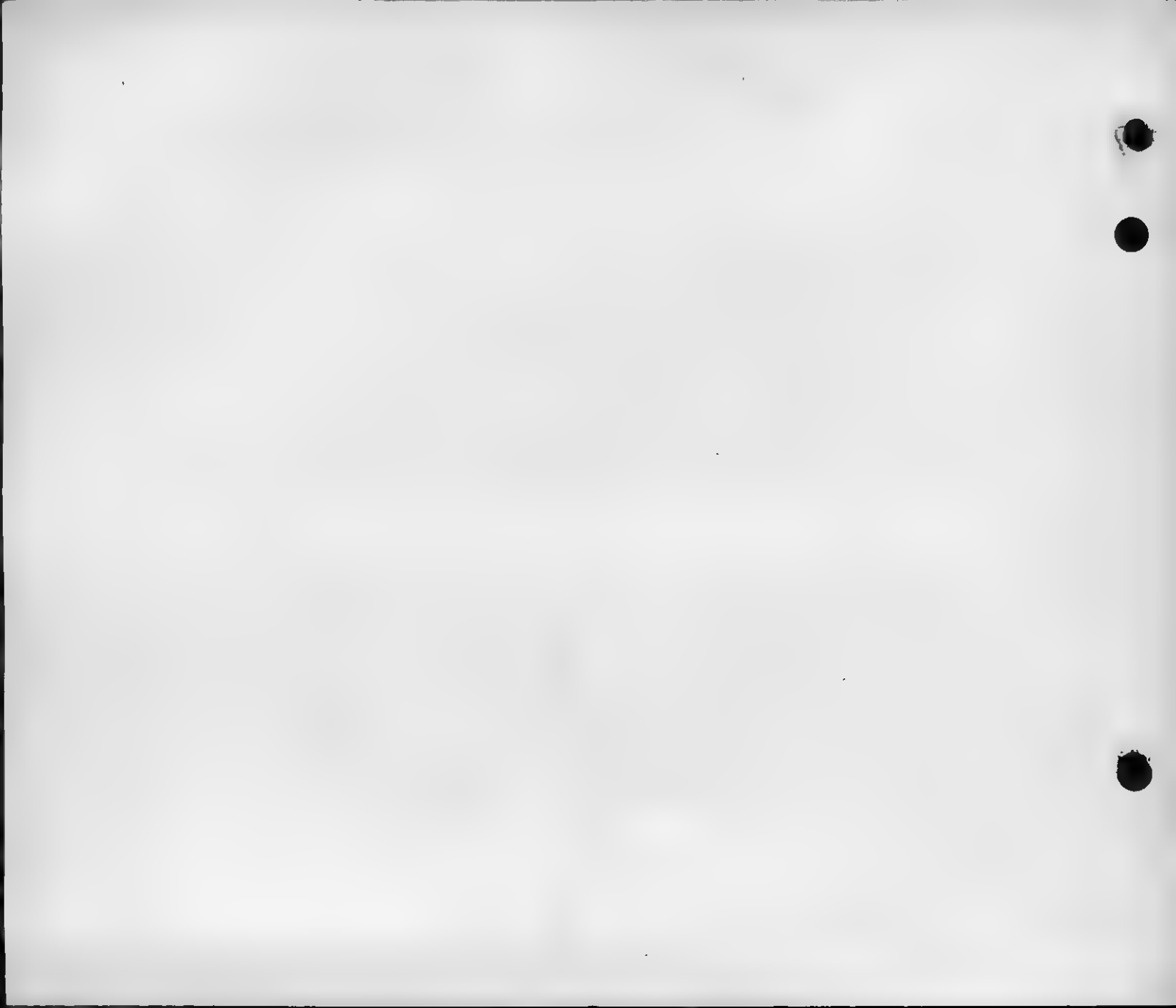
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03733

3769

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>26 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>887 Hamilton Place - Lavy, Maryland</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>F</u> Last <u>Lindenmayer</u>		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	9c. AGE (In years last birthday) <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	10c. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Charles Lindenmayer - 2026 Chamberlane Ave. Richmond, Virginia</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardiovascular disease.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>3-14-1956</u> to <u>4-9-1956</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachler</u>		M.D. <u>Spring Grove State Hospital</u> <u>4-9-56</u>	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>		<u>Catonsville 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>CREMATION</u>	<u>APR 11, 1956</u>	<u>CREMATION</u>	<u>BALTO, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Smith</u>		24. REC'D BY REGISTRAR DATE <u>11 1956</u>	
ADDRESS <u>Harlock, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	

BUREAU V. S.

APR

1950

CERTIFICATE OF DEATH

Reg. Dist. No. 30

3770

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN 1b <b>11 days</b>		d. STREET ADDRESS <b>127 W. BURNETT ST.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JULIUS</b> Middle <b>LUEDTKE</b> Last		4. DATE OF DEATH Month <b>4</b> Day <b>29</b> Year <b>56</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-98</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 19 HRS Months <b>10</b> Days <b>10</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Katherine ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Records, Spring Grove Hosp.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>general debility</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-19-56</b> to <b>4-29-56</b> , that I last saw the deceased alive on <b>4-29-56</b> , and that death occurred at <b>10:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harold Salvores MD</b>		M.D. <b>Spring Grove Hospital</b> <b>Catonville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>DAVID EDWARDS MD</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 2-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Ritchie Highway Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kramer Funeral Home</b>		ADDRESS <b>1216 S Charles St.</b>	
24a. REC'D BY REGISTRAR DATE <b>5/4/56</b>		24b. REGISTRAR'S SIGNATURE <b>Victor C. Hary</b>	

MEDICAL CERTIFICATION

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 31

MAY 4 1956

151

MARYLAND STATE DEPARTMENT OF HEALTH

03735

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

3771

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MD.</b> COUNTY <b>BALTO</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>SPARKS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>SPARKS</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Quaker Bottom Rd.</b>		STREET ADDRESS (If rural, give location) <b>Quaker Bottom Rd.</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>BLANCHE</b>	(Middle) <b>PEARL</b>	(Last) <b>VINLA MADDEN</b>
4. DATE OF DEATH	(Month) <b>APRIL</b>	(Day) <b>22</b>	(Year) <b>1956</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>NOV. 27 1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN JENKINS</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE PAXTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY No. <b>215-22-7862</b>	
17. INFORMANT AND ADDRESS <b>Flla I Ringgold, Cockeysville, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<input checked="" type="checkbox"/> Immediate cause (a) <b>CARCINOMA OF BREAST</b> Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		<b>2 YRS</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTENT OF CAUSE PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.		
SIGNATURE <b>William A. Pillsbury M.D.</b>		DATE SIGNED <b>4/22/56</b>
23. CREMATION (Yes or No) <b>Buried</b>	DATE THEREOF <b>2-26-56</b>	NAME OF CEMETERY OR CREMATORY <b>Stephenson A.M.F.</b>
LOCATION (City, town, or county) <b>Sparks, Md.</b>	(State)	
24. FUNERAL DIRECTOR	ADDRESS	
<b>26 April 1956</b>	<b>Scott Brooks</b>	

MARGIN RESERVED FOR BINDING

USE WRITING PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. A.M.A.

BURDET V. S.

APR 1 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03736

3659

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> TOWN <u>Dundalk</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>30 Eastship</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u></u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> TOWN <u>Dundalk</u> STREET ADDRESS (If rural, give location) <u>30 Eastship</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>L.</u> (Middle) <u>Makin</u> (Last)		4. DATE OF DEATH <u>April 1, 1956</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Sept. 8, 1873</u>
9. AGE last birthday <u>82</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>M.C. Harlow</u>		14. MOTHER'S MAIDEN NAME <u>E.T. Falls</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT <u>John B. Henderson 30 Eastship</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>arteriosclerotic cardiac - renal disease</u>		
Antecedent cause(s) (b) <u>Senility</u>		<u>5 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>		<u>3 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 12, 1945, to April 1, 1956, that I last saw the deceased alive on March 25, 1956, and that death occurred at 12:30 P. m., from the causes and on the date stated above.

SIGNATURE Marion H. Andrew M.D. (Degree or title) ADDRESS 33 Dundalk Ave Dundalk Md 21217 DATE SIGNED April 2 1956

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
<u>Burial</u>	<u>Apr. 4, 1956</u>	<u>Oak Lawn</u>	<u>Colgate, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 3, 1956</u>	<u>A. W. Hedrich</u>	<u>Ullrich Funeral Home</u>	<u>2112 Dundalk Ave.</u>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

037374

Reg. Dist. No.

3772

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastwood</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastwood</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7701 Eastdale Road</b>				d. STREET ADDRESS <b>7701 Eastdale Road</b>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>WILSON</b> Last <b>MANGUM</b>				4. DATE OF DEATH <b>April 29</b> <span style="float: right;">Month <b>April</b> Day <b>29</b> Year <b>19 56</b></span>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1935</b>		9. AGE (In years last birthday) <b>21</b> yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Woodrow Mangum</b>				14. MOTHER'S MAIDEN NAME <b>Rita Laird</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>yes Navy current</b>		16. SOCIAL SECURITY NO. <b>current</b>		17. INFORMANT Address <b>Woodrow Mangum, father, 7701 Eastdale Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9776x GUN SHOT WOUND (22 CAL RIFLE) -</b> <b>THRU BRAIN-ENTERING BETWEEN EYES +</b> Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b> (c) <b>RUNNING UPWARDS -</b> cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>SHOT SELF THRU HEAD</b>					
20c. TIME OF INJURY Hour <b>4:25</b> p. m. <b>4-29-56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>		20f. (City or town) <b>EASTWOOD - BALTO - MD</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M.B. Davis</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 2, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Schimunek Funeral Home, 2601 E. Madison St. Baltimore, 5, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>5/2/56</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. P. Kelly</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 2 19

RECEIVED

03738

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3773

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines</u>		STREET ADDRESS (If rural, give location) <u>6921 Reisterstown Road</u>	
3. NAME OF DECEASED (Type or Print) <u>SARAH</u>		(Last) <u>MARKS</u>	
4. SEX <u>Female</u>		5. DATE OF DEATH <u>4</u> (Month) <u>15</u> (Day) <u>1956</u> (Year)	
6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		9. AGE last birthday <u>69</u> yrs.	
10. FATHER'S NAME <u>Simon</u>		11. BIRTHPLACE (State or foreign country) <u>Manchester Eng</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		13. MOTHER'S MAIDEN NAME <u>Lena</u>	
14. SOCIAL SECURITY NO. <u>(blank)</u>		15. INFORMANT AND ADDRESS <u>Albert Marks - Same</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)---

Antecedent cause(s) (b)---

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

Cerebral hemorrhage  
generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

1 week  
10 yearsII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

Coronary thrombosis

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/11</u> , 19 <u>56</u> , to <u>4/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Bernard J. Gurgin, M.D.</u>		(Degree or title)		ADDRESS <u>2100 Eutaw Rd</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>		DATE THEREOF <u>4-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>	
DATE REC'D. BY LOCAL REG. <u>April 16, 1956</u>		REGISTRAR'S SIGNATURE <u>Charles H. G. Gurgin</u>		24. FUNERAL DIRECTOR <u>2100 Eutaw Rd</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physically: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03739

3774

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Balto.</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>25 Edmondson Ridge Rd.</b>				STREET ADDRESS (If rural give location) <b>25 Edmondson Ridge Rd.</b>			
3. NAME OF DECEASED (Type or Print) <b>JAMES HENRY MARSH</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Apr. 14, 1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>Dec. 16, 1877</b>		9. AGE last birthday <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Ship Builder Self Emp.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>James T. Marsh</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Snowden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-03-2895</b>		17. INFORMANT & ADDRESS <b>Mr. John A. Harrison, Sr.-25 Edmondson Ridge Rd.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
241X IMMEDIATE CAUSE (A) <b>G.P.C. of Lung</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
ANTECEDENT CAUSE(S) DUE TO				<b>Cochlear carcinoma - bronchus - emphysema -</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<b>bronchitis - asthma -</b>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 2</b> , 19 <b>56</b> , to <b>Apr 14</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Apr 14</b> , 19 <b>56</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>D. E. Korman</b>		M.D.		ADDRESS (Street, city, town, state) <b>1202 81st Ave S</b>		DATE SIGNED <b>4/16/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>4/18/56</b>		NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>		LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <b>D. E. Korman</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Trachtenberg</b>		ADDRESS <b>4000 Baiter Rd</b>	

BUREAU V. S.

APR 1

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3775

CERTIFICATE OF DEATH

Reg. Dist. No.

037440

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hillside Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LILLIAN E. MAYNARD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27th</b> Year <b>19 56</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 20, 1920</b>
9 AGE (In years last birthday) <b>36 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Raymond R. Dilworth</b>		14. MOTHER'S MAIDEN NAME <b>Mabel C. Dilworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Raymond L. Maynard, Hillside Rd., Kingsville</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Scirrhus Carcinoma of duct of breast with wide spread metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>39 Month</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/26/56</b> to <b>4/27/56</b> , that I last saw the deceased alive on <b>2/26/56</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above ADDRESS, street, city or town, state) <b>Fork, Md.</b> DATE SIGNED <b>4/28/56</b> ACTUAL SIGNATURE <b>Clifford F. Hudson</b> M.D. PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/30/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fork Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fork, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassiter Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Walter Hemmelt</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1911

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03742

3776

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Riderwood, Baltimore</u> <u>MARYLAND</u> County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>624 S. Bond Street</u>			
c. LENGTH OF STAY IN 1b <u>since 12-30-1955</u>				d. STREET ADDRESS <u>7912 Ruxway Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sorensen Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MAYO</u> Last <u>MAYO</u>				4. DATE OF DEATH Month <u>April</u> Day <u>eleventh</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 2, 1876</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>indstryman</u>		11. BIRTHPLACE (State or foreign country) <u>Mandrio Provience,</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Argentina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>not known</u>				16. SOCIAL SECURITY NO. <u>217-14-0590</u>			
17. INFORMANT <u>Frank Michalski, 624 S. Bond Street</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricle failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertrophy myocardium with weakness</u> DUE TO (c) <u>Myocarditis chronic.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>few months</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac asthma associated with left ventricular failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m. <u>none</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>no injury</u>	
20f. (City or town) <u>no injury</u>				20g. (County) <u>no injury</u>		20h. (State) <u>no injury</u>	
21. I certify that I attended the deceased from <u>Dec. 30th, 1955</u> to <u>April 11, 1956</u> , that I last saw the deceased alive on <u>April seven, 1956</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James Graham Marston</u>				ADDRESS (Street, city or town, state) <u>516 Cathedral Street</u>			
PHYSICIAN'S NAME (Type) <u>James Graham Marston, M.D.</u>				DATE SIGNED <u>4-11-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc.</u>				ADDRESS <u>1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>APR 16 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mabel Shays</u>							

JOHN V. S.

APR 1

## 3777 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Town</u> <u>Rural: Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium</u>		STREET ADDRESS (If rural give location) <u>1733 N. Payson St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>ENOS</u>	(Middle) <u>Elmer</u>	(Last) <u>Mellott</u>	(Month) <u>4</u> (Day) <u>13</u> (Year) <u>1956</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9/14/05</u>
9. AGE last birthday: <u>50</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Meat Cuts Army Commissary</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore City</u>	
11. BIRTHPLACE (State or foreign country): <u>US</u>		12. CITIZEN OF WHAT COUNTRY: <u>US</u>	
13. FATHER'S NAME: <u>Enos E Mellott</u>		14. MOTHER'S MAIDEN NAME: <u>Rose Shipley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No: <u>215-03-6958</u>	
17. INFORMANT & ADDRESS: <u>Personal History</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypertensive Cardiovascular Disease Interval Between Onset And Death 6 mos.

Antecedent causes (s) DUE TO (b) Coronary Involvement, Antero-lateral Myo-cardial Damage 4 mos.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3/28, 1956, to 4/13, 1956, that I last saw the deceased alive on 4/13, 1956, and that death occurred at 3:10 PM, from the causes and on the date stated above.

SIGNATURE William B. Kuss M.D. ADDRESS Eudowood Sanatorium - Towson 4, Maryland DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 16-1956</u>	<u>MT. OLIVET CEM.</u>	<u>BALTO. MARYLAND</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>APR 15 1956</u>	<u>William B. Kuss</u>	<u>E. Truman Schwalbe</u>	<u>3512 Frederick Ave. (29)</u>

MARGIN RESERVED FOR BENDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3778

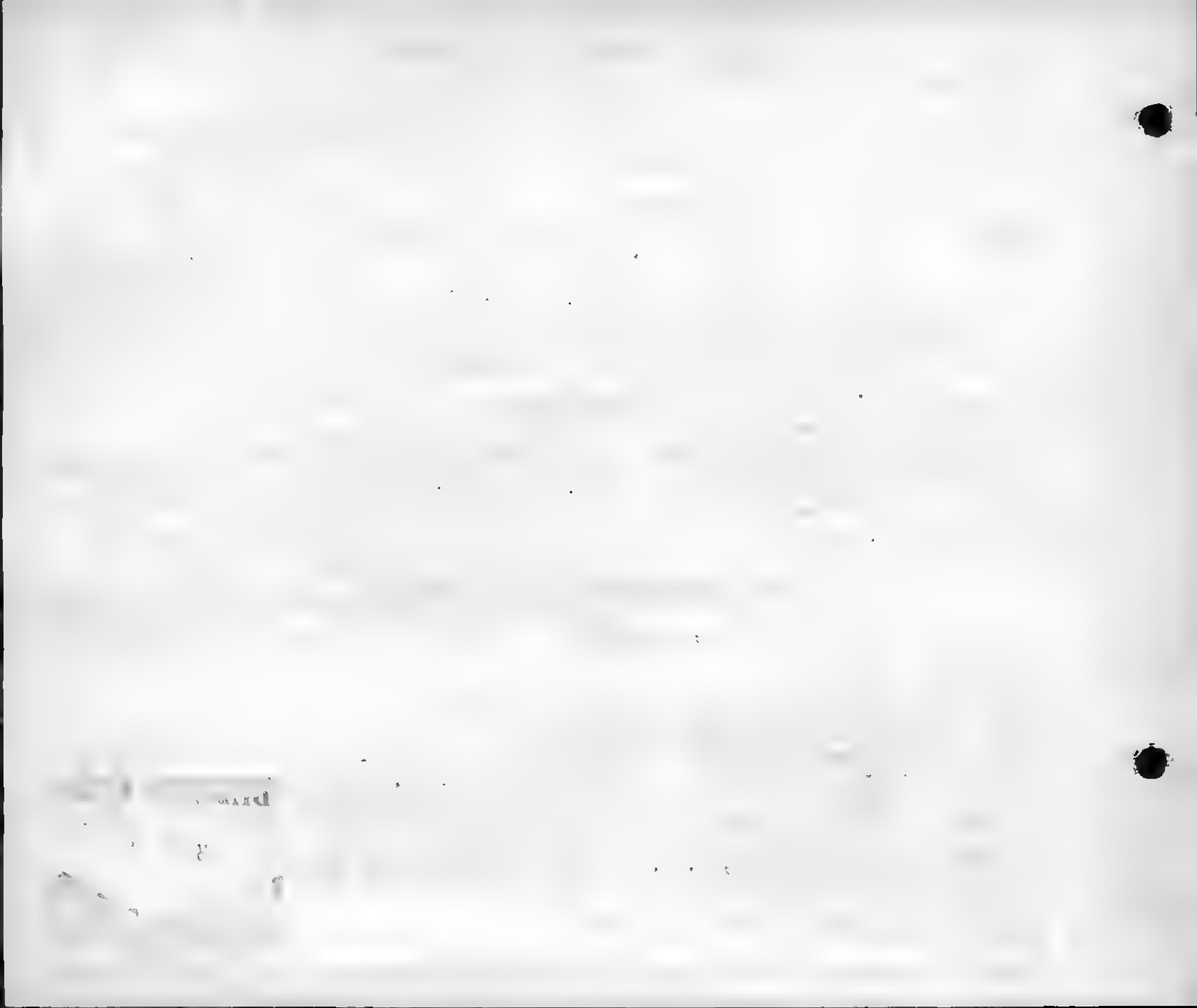
## CERTIFICATE OF DEATH

03744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>			d. STREET ADDRESS <u>132 West Clement Street</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>George S. Miller</u>			4. DATE OF DEATH Month Day Year <u>April 23, 19 56</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1893</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>National Bar</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>Frank P. Miller</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		
17. INFORMANT <u>Records Spring Grove State Hospital</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Old extensive myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Pangerositis due to failing heart</u>					INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Pulmonary edema, terminal</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>7a</u> <u>1953</u> to <u>4-23</u> <u>19 56</u> ; that I last saw the deceased alive on <u>4-23</u> <u>19 56</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u>		DATE SIGNED <u>4-23-56</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial April 26, 1956</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Evans</u>		ADDRESS <u>1400 S. Charles St.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>V. E. Harry</u>

APR 25 1956





3779

## CERTIFICATE OF DEATH

Reg. Dist. No.

35-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>36 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Carmel Rd.</u>		d. STREET ADDRESS <u>Mt. Carmel Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>K.</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1956</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Yard</u>	
11 BIRTHPLACE (State or foreign country) <u>Parkton, Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William Miller</u>		14 MOTHER'S MAIDEN NAME <u>Sarepta Gore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-18-4468</u>	
17. INFORMANT <u>Mrs. Martha Miller, Parkton, Md. R.D.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Cardio Vascular Disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18] <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Jan 1, 1956</u> to <u>Apr 1, 1956</u> , that I last saw the deceased alive on <u>Apr 1, 1956</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u>	
DATE SIGNED <u>Apr 1, 1956</u>		DATE SIGNED <u>Apr 1, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 4, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hereford Baptist Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Hereford Balto Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David Kurlenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Robert J. Fiedler</u>	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 3780  
 CERTIFICATE OF DEATH

Reg. Dist. No.

0374633-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>62 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Vernon</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Beckleysville, Md.</u>
13. FATHER'S NAME <u>James C. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Clara M. Cullough</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> <u>Aug. 18 - July 19, 1954</u>		16. SOCIAL SECURITY NO. <u>214-225424</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>12/31</u> , 19 <u>55</u> , to <u>4/6/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/5/56</u> , 19 <u>55</u> , and that death occurred at <u>12/31 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. <u>Parkton, Md.</u> DATE SIGNED <u>4/7/56</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 8, 1956</u>	<u>Wiseburg Cemetery</u>	<u>White Hall, Balto. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Nordenshtein</u>		24a. REC'D BY REGISTRAR DATE <u>4/7/56</u>	24b. REGISTRAR'S SIGNATURE <u>Charles J. Fulton</u>

NEW YORK

APR 10 1956

RECEIVED

3781

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.U.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>68 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>5329 Patrick Henry Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>STANLEY A. MOCARSKY</u>				4. DATE OF DEATH Month Day Year <u>April 3 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10, 1914</u>	
9. AGE (In years lost birthday) <u>41 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete Business</u>		11. BIRTHPLACE (State or foreign country) <u>Springfield, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Stanley A. Mocarsky</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO <u>217-14-5762</u>			
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE MYELOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>                    </u> DUE TO (c) <u>                    </u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <u>VA</u> attended the deceased from <u>January 26, 1956</u> , to <u>April 3, 1956</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D. <u>VAH Ft. Howard, Md</u>				DATE SIGNED <u>4/4/56</u>			
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>				ADDRESS (Street, city or town, state) <u>VAH FT. Howard, Md</u>			
DATE SIGNED <u>4/4/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Cvach Funeral Home</u>				ADDRESS <u>900 N. Chester St. Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>                    </u> DATE <u>APR 5 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>                    </u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03748

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>2yrs. 29days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>1122 Hollins Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <u>William</u></span> <span>Middle</span> <span>Last <u>Moon</u></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <u>April</u></span> <span>Day <u>20,</u></span> <span>Year <u>19 56</u></span> </div>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-18-1874</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>Joseph Moon</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Frances ?</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> <u>Records Spring Grove State Hospital</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Infarction of occipital lobes of brain</u>  <u>44ix</u> <b>DUE TO</b>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b> <u>Due to arteriosclerosis, Pulmonary edema</u>  <b>DUE TO</b>  <b>(c)</b> <u>Chronic Nephrosclerosis, Chr. Bronchitis</u> </div>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> 		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Salivaceous hemorrhages of right side face</u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) 					
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a. m. <span style="margin-left: 20px;">Month, Day, Year</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>			
<b>20f. (City or town)</b> <u>Catonsville</u>		<b>(County)</b> <u>Baltimore</u>		<b>(State)</b> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>George S. K. Kieffer</u>			<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>George S. K. Kieffer, M. D.</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DATE SIGNED</b> <u>4-21-56</u>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>April 24, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Ritchie Highway Balto. Md.</u>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>KRAUSE FUNERAL HOME 1216S. Charles St.</u>			<b>ADDRESS</b>				
<b>24a. REC'D BY REGISTRAR</b> <u>APR 27 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>V. E. Harrys</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU U. S.

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3783

## CERTIFICATE OF DEATH

03749

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>SPRING GROVE STATE HOSPITAL</i>		d. STREET ADDRESS <i>Monroton, Maryland</i>	
3. NAME OF DECEASED (Type or print) <i>Wilhelmina Moselsy</i>		4. DATE OF DEATH Month <i>April</i> Day <i>28</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7.26.1873</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John Moselsy</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Medical Record.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease infarction</i> <i>4x20.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 or 3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>APRIL</i> , 19____, to <i>April 28</i> , 19____, that I last saw the deceased alive on <i>April 28</i> , 19____, and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>D. P. [Signature]</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>5/1/56</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Greenwood Hill</i>		<i>Brooklyn Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles P. Hill</i>		24a. REC'D BY REGISTRAR DATE <i>5/1/56</i>	
ADDRESS <i>1501 E. Falls</i>		24b. REGISTRAR'S SIGNATURE <i>J. E. Harry</i>	

BUREAU V. S.

MAY 2 1

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03750

3784

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenvar Rd.</u>		STREET ADDRESS (If rural, give location) <u>Glenvar Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Eustachia Muench</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>28</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 5, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	9. AGE last birthday <u>89</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Newark, N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Muench</u>		14. MOTHER'S MAIDEN NAME <u>Kuna Grotzer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of)</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff Md</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Bed-ridden 3 yrs. infirmity of old age

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 9, 1952, to April 28, 1956, that I last saw the deceased

alive on Feb. 7, 1956, and that death occurred at 9:00 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>5-1-56</u>	<u>VILLA MARIA LEM.</u>	<u>NOTCH CLIFF NR TOWSON, MD</u>	
DATE REC'D. BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4 30 56</u>	<u>Notar Public</u>	<u>Charles J. Geier</u>	<u>901 S. CONKLING ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

03751

3785

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4303 Belmar Ave.</u>		STREET ADDRESS (If rural, give location) <u>4303 Belmar Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Helen Marie Naegele</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>4</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2 Sept 03</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>52</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles R. Collier</u>		14. MOTHER'S MAIDEN NAME <u>Lavenia B. Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Joseph A. Naegele - 4803 Belmar Ave.</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			<u>Immediate</u>
Immediate cause (a) <u>Carbon Monoxide Poisoning</u>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Depressive Psychosis</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>3-4 yrs.</u>
19a. DATE OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.			
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY			HOW DID INJURY OCCUR?
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input checked="" type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>John C. Kyle M.D. Hlth. Off. Md. St. 7527 Belair Rd</u>			DATE SIGNED <u>4-4-56</u>
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>		<u>April 7 1956</u>	<u>Parkwood</u>
LOCATION (City, town, or county) (State)		<u>Baltimore, Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>April 15, 1956</u>		<u>T. W. [Signature]</u>	<u>Sassahn Funeral Home 7401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

carbon monoxide suffocated - running car in closed garage.

3786

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines Fusting Ave.</b>				d. STREET ADDRESS <b>906 Walnut Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>M.</b> Last <b>NELSON</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 22, 1875</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Wode</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Alcock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. A. L. Bobbitt - 602 Walnut Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>gangren, right leg</b> DUE TO (c) <b>arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>4 days</b> <b>3</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>May 1953</b> , to <b>April 26, 1956</b> , that I last saw the deceased alive on <b>April 25, 1956</b> , and that death occurred at <b>1:58 P.M.</b> from the causes and on the date stated above							
ACTUAL SIGNATURE <b>D. C. MacLaughlin</b>				ADDRESS (Street, city or town, state) <b>4508 Edmondson Village</b>			
PHYSICIAN'S NAME (Type) <b>D. C. MacLaughlin, M. D.</b>				DATE SIGNED <b>4-26-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Vickers &amp; Sons - Balt.</b>				24. REGISTAR'S SIGNATURE <b>Wm. J. Vickers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03753  
40  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Fork Md.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>HAROLD A. NEVEL</b>		4. DATE OF DEATH <b>April 23 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1904</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jesse Nevel</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Cooney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hazel E. Nevel</b>		Address	
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertensive Cardiovascular Dis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>? 1 yr.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Stroke</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-1-1955</b> to <b>4-23-56</b> , that I last saw the deceased alive on <b>2-22-56</b> , and that death occurred at <b>3:55 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clifford F. Hudson</b>		ADDRESS (Street, city or town, state) <b>Fork, Md.</b> DATE SIGNED <b>4/23/56</b>	
PRINTED NAME (Type) <b>CLIFFORD F. HUDSON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 25 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lanahan Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
ADDRESS <b>7401 Belair Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Walter Hammett</b>	

U.S. AIR FORCE

PR

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03754

3788

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2 months 13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> X			
d. STREET ADDRESS <u>109 Church Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dr. Elijah Emora Nichols</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-1885</u>	9. AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Elijah Nichols</u>			
14. MOTHER'S MAIDEN NAME <u>Mariah Jane Williams</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Records Spring Grove State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO <u>440.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis, left paraplegia</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Swollen feet, decubitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. p.</u> Month <u>19</u> Day <u>  </u> Year <u>  </u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1-24</u> , 19 <u>56</u> , to <u>4-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>56</u> , and that death occurred at <u>2:50 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gulla Wachler</u>				M.D. <u>Spring Grove State Hospital</u> <u>4-6-56</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachler</u>				M. D. <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-9-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				ADDRESS <u>Pikesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-9-56</u>	
24b. REGISTRAR'S SIGNATURE <u>T. E. Hays</u>							

RECEIVED

APR 10 1956

BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3671

## CERTIFICATE OF DEATH

03755 47

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b <b>?</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4606 Leeds Ave</b>		d. STREET ADDRESS <b>4606 Leeds Ave</b>	
3. NAME OF DECEASED (Type or print) <b>William Frederick Niepraschk</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 27, 1890</b>
9. AGE (in years last birthday) <b>66</b>		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PBX Installer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gustav Niepraschk</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Frank</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-03-6832</b>	
17. INFORMANT <b>Mamie Niepraschk, 4606 Leeds Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hyper-tensive Cardio-vascular disease</b> (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema - Bilateral</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>April 11, 1956</b> to <b>April 27, 1956</b> , that I last saw the deceased alive on <b>April 11, 1956</b> , and that death occurred at <b>3 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>EARL PASS, M.D.</b>		ADDRESS (Street, city or town, state) <b>4001 Wilkens Ave</b>	
PHYSICIAN'S NAME (Type) <b>EARL PASS, M.D.</b>		DATE SIGNED <b>4-29-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-30-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR <b>DATE 1 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. G. M. Luff</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

## 3789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03756  
20

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>27 N. Carey Street</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Annie</b> Middle <b>NMI</b> Last <b>Obst</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>1</b> Year <b>19 56</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Mar. 14, 1881</b>		<b>9. AGE</b> (In years last birthday) <b>75 yrs.</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Baltimore</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.</b>			
<b>13. FATHER'S NAME</b> <b>Wallace Jones</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Kate KENSEL</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Unknown</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-14-0399A</b>		<b>17. INFORMANT</b> <b>Records: Spring Grove State Hospital</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>420.1</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary Thrombosis</b> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <b>Arteriosclerotic Cardiovascular disease</b> <b>DUE TO</b> <b>(c)</b> <b>Cholesterol</b>					<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME (Type)</b> <b>C. E. O. S. M. KIEFFER</b>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>April 56</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>4-4-56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>MT OLIVET</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm Cook - Blight Inc</b>		<b>ADDRESS</b> <b>6009 Harford Rd</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>4/3/56</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <b>J E Hays</b>		<b>24c. LOCATION (City, town, or county)</b> (State) <b>2730 FREDERICK AVE</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU, W. A.

APR 4 1956

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3790

CERTIFICATE OF DEATH

Reg. Dist. No. 0375733

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Tr Schol</u>		d. STREET ADDRESS <u>2920 N Calvert-51-</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Edward O'Meara</u>		4. DATE OF DEATH <u>April 14 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>10/18/50</u>	9. AGE (in years last birthday) <u>5</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. 17.</u>	
13. FATHER'S NAME <u>Jerome T. O'Meara</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Welker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records, Rosewood, Bowings Mills</u>		Address <u>Bowings Mills</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Failure of respiration, central</u> DUE TO <u>Increased intracranial pressure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congenital hypertensive hydrocephalus</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles L. Gualala</u> M.D.		ADDRESS (Street, city or town, state) <u>2920 N. Calvert, #18</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>16 1956</u>	
ADDRESS <u>3818 Roland Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Mary G. —</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. The form may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WORTHINGTON

APR 1951

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03758  
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3791

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>11 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
f. STREET ADDRESS <b>1618 PORTUGAL STREET</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VALENTINE</b> Middle <b>J.</b> Last <b>PALASIK</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-11</b>
9. AGE (In years last birthday) <b>45</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARTENDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>VALENTINE PALASIK</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA NOVAK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>WW-11</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FORT HOWARD, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMATEMESIS</b> <b>5810</b> DUE TO <b>ESOPHAGEAL VARICES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Due to: CIRRHOSIS OF LIVER</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RHEUMATIC HEART DISEASE WITH MITRAL INVOLVEMENT * DURATION UNKNOWN</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 27</b> , 1956, to <b>April 7</b> , 1956, and that death occurred at <b>6:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>4-7-56</b>			
ACTUAL SIGNATURE <i>John A. Surmonte</i>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>John A. Surmonte, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/11/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE 22, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William S. Fialkowski</b> ADDRESS <b>William S. Fialkowski Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <i>Shirley A. Fisher</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 10 1956

Continued on next page

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3792 CERTIFICATE OF DEATH

Reg. Dist. No.

03759-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>White Hall Rd.</u>		d. STREET ADDRESS <u>White Hall Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles L. Pearce</u>		4. DATE OF DEATH <u>April 18, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 30, 1881</u>
9. AGE (In years, last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Mail</u>	
11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph W. Pearce</u>		14. MOTHER'S MAIDEN NAME <u>Frances Lytle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Anne Pearce</u>		Address <u>White Hall Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RENAL DISEASE</u> DUE TO (c) <u>5 YRS.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN.</u> , 1953, to <u>APRIL 18</u> , 1956, that I last saw the deceased alive on <u>APRIL 18</u> , 1956, and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lloyd E. Saylor</u> M.D.		ADDRESS (Street, city or town, state) <u>3902 GREENMOUNT AVE.</u>	
PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor</u>		DATE SIGNED <u>BALTIMORE-18 MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 21, 1956</u>	<u>Vernon Cemetery</u>	<u>White Hall Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		24. REC'D BY REGISTRAR <u>Cherita J. Fulton</u>	
ADDRESS <u>New Freedom Pa.</u>		DATE <u>4/19/56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR FORCE

OFFICE OF THE

DEAFEN

3793

03761

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>md.</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	LENGTH OF STAY (In this place) <i>6 weeks</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>R. J. E. 4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Perryman Lane Reisterstown</i>		STREET ADDRESS (If rural, give location) <i>Manchester Road</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Hubert</i>	(Middle)	(Last) <i>Poff</i>	(Month) <i>April</i> (Day) <i>24</i> (Year) <i>1956</i>
5. SEX: <i>m.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Feb. 6, 1932</i>
9. AGE last birthday: <i>24</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Farm Manager</i>	
11. BIRTHPLACE (State or foreign country): <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Percy Poff</i>		14. MOTHER'S MAIDEN NAME: <i>Eva Puckett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no.</i>		16. SOCIAL SECURITY No.: <i>215-26-1181</i>	
17. INFORMANT & ADDRESS: <i>Clayton W. Poff, Hampstead md</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Crushed sternum, back &amp; upper left chest with internal hemorrhage &amp; asphyxia</i>			<i>50 min.?</i>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>none</i>			
19a. DATE OF OPERATION: <i>none</i>		19b. MAJOR FINDING OF OPERATION: <i>none</i>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street office bldg., etc.) <i>Larkin's farm</i>	
21c. (City or town) (County) (State) <i>Reisterstown Balto. Md.</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>4-24-56 3:48 P. M.</i>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>Deceased backed tractor under overhang of barn &amp; was crushed up against steering wheel</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>J. D. Caples</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>4-26-56</i>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>April 27, 56</i>	
NAME OF CEMETERY OR CREMATORY <i>Piney Grove Cemetery</i>		LOCATION (City, town, or county) (State) <i>Mount Airy md.</i>	
DATE REC'D BY LOCAL REG. <i>4-26-56</i>		24. FUNERAL DIRECTOR <i>Mr. J. B. Gorman &amp; Sons Reisterstown, md.</i>	
REGISTRAR'S SIGNATURE <i>Mary B. Stone</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BURBANK A. S.

APR 27 1955

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3794

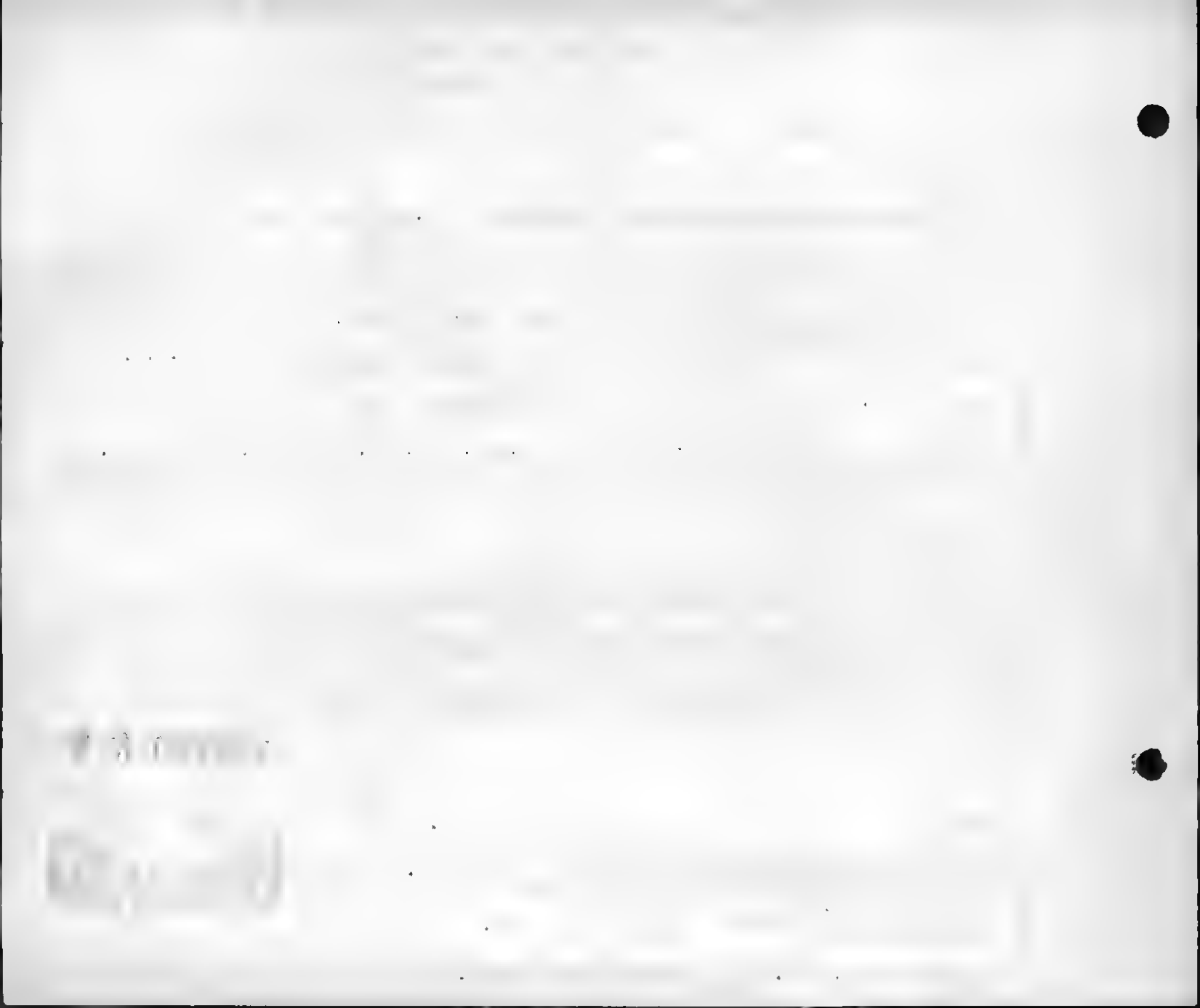
## CERTIFICATE OF DEATH

## 03762

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>7 Days</u>		d STREET ADDRESS <u>115 N. Clinton Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLINTON</u> Middle <u>M</u> Last <u>POWELL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1897</u>
9. AGE (In years last birthday) <u>58 yrs.</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>56</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilhost, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin L. Powell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO <u>213-05-2666</u>	
17. INFORMANT <u>CLIN. REC. VET. ADM. HOSP.</u>		Address <u>FT. HOWARD, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 29, 1956</u> , to <u>April 5, 1956</u> , that I last saw the deceased <u>alive</u> and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH Ft. Howard, Maryland</u> DATE SIGNED <u>4/5/56</u>			
ACTUAL SIGNATURE <u>Francis G. Dickey</u>		M.D. <u>VAH Ft. Howard, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>FRANCIS G. DICKEY</u>		<u>VAH Ft. Howard, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 9, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jilly &amp; Zeiler, Inc.</u>		ADDRESS <u>Eastern &amp; Wolfe St. Balto. Md.</u>	
24a. REC'D BY REGISTRAR <u>April 7, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>R. W. Dawson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03763

3795

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		CITY <u>BALTIMORE</u>		TOWN <u>SPARKS</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BALTIMORE COUNTY HOME</u>		<u>1 mo. 1954</u>					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JAMES HENRY POWELL</u>				<u>15</u> <u>19</u> <u>54</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Widowed</u>	<u>2</u>	<u>46</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>				<u>NORFOLK VIRGINIA</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JAMES POWELL</u>				<u>MARY WEST</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>215-32-9607A</u>		<u>JOHN MOSBY SPARKS JR.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
11221 IMMEDIATE CAUSE (A) <u>Cardiac decompensation</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Intensive cardiac catheterization</u>						<u>weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>						<u>✓</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 14, 1954</u> to <u>April 14, 1956</u> , that I last saw the deceased alive on <u>April 14, 1956</u> , and that death occurred at <u>6:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. Powell</u> M.D.				ADDRESS (Street, city, town, state) <u>Cockeysville Md.</u>		DATE SIGNED <u>4/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY, OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/19/56</u>		<u>St. Luke's</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>4-5-56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

APR 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03764

3796

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>818 Shuter St. Balto Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fullerton Md.</u>		STREET ADDRESS (If rural, give location) <u>818 Shuter St</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Robert</u> <u>Proctor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7</u> <u>16</u> <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, <del>MARRIED</del> , WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec 11, 1900</u>
9. AGE last birthday <u>55</u> yrs.		10. DATE OF BIRTH <u>Dec 11, 1900</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Abraham Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Hester Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Clara Dixon 9377 Dallas St</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>Annndy</u>	
Antecedent cause(s) (b) <u>Generalized Atherosclerosis</u>		<u>Under</u>	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy Inspection <input checked="" type="checkbox"/> Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>John C. Mc</u>		ADDRESS <u>Mt. Mt. 7527 Belair Rd</u>	
DATE SIGNED <u>4/5/56</u>			
23. METHOD OF REMOVAL (Specify) <u>Private</u>		DATE THEREOF <u>April 10/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		LOCATION (City, town, or county) (State) <u>A. C. County Md.</u>	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR <u>Mrs. Robert A. Elliott &amp; Daughter</u>	
REGISTRAR'S SIGNATURE		ADDRESS <u>11297 Caroline St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct air is especially important. Physicians: please write the cause of death clearly and legibly.



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03765

3797

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN TB <b>2yr11mos5days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>D.</b> Last <b>Provonche, Sr.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-29-1888</b>	9. AGE (In years last birthday) <b>68 7/8</b> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MD. CASUALTY CO.</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown WISCONSIN</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Unknown U.S.A.</b>							
13. FATHER'S NAME <b>Unknown CHARLES C. PROVONCHE</b>				14. MOTHER'S MAIDEN NAME <b>Unknown ANNA Z. GILLETTE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records Spring Grove State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia, bilateral</b> DUE TO <b>490x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10 days</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Brain Disease</b> Years <b>74 1/2</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>4-28-</b> , 19 <b>53</b> , to <b>4-2-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 2</b> , 19 <b>56</b> , and that death occurred at <b>7:45</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b> DATE SIGNED <b>4/2/56</b>							
ACTUAL SIGNATURE <b>Joseph R. Cowen</b>				M.D. <b>Spring Grove State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Joseph R. Cowen, M. D.</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-6-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>FOOT MEYER U.S.A.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Hyatt</b>				ADDRESS <b>3444 BELAIR RD.</b>		24a. REC'D BY REGISTRAR <b>Constance J. Ullrich</b>	
				DATE <b>1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Hays</b>	

E. A. OYEN

1 - 32



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3798

CERTIFICATE OF DEATH

03766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Villa Julie</u>				d. STREET ADDRESS <u>Valley Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Sister Augustine Julie (Quinn)</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1893</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Thomas Quinn</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Quinn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO <u>  </u>		17. INFORMANT <u>Sister Marie Dolores Villa Julie</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocarditis with Pulmonary Embolism</u> <u>442 X</u> DUE TO <u>Cardio - Renal vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>Staph - auric hemolytic abscess - base of spine</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While a. m. <u>  </u> of work <input type="checkbox"/> Not while a. m. <u>  </u> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I attended the deceased from <u>Feb. 19, 1956</u> to <u>April 21, 1959</u> , that I last saw the deceased alive on <u>April 21, 1959</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 E. Taper St.</u> DATE SIGNED <u>4/23/56</u>							
ACTUAL SIGNATURE <u>Harold H. Burns</u> M.D.				PHYSICIAN'S NAME (Type) <u>Harold H. Burns, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ilchester Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>For My Funeral Home - Catonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Miss Mabel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 1 1950  
PUEBLO 17

## CERTIFICATE OF DEATH

Reg. Dist. No. 037620

3799

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>LIFETIME</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PARADISE NURSING HOME</b>		e. STREET ADDRESS <b>42 S. CAROLTON AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>J</b> Last <b>Rabe</b>		4. DATE OF DEATH Month <b>4</b> Day <b>12</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-20-1873</b>
9. AGE (In years, birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BANK</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANDREW Rabe</b>		14. MOTHER'S MAIDEN NAME <b>AGNES EICHELMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-09098</b>	
17. INFORMANT <b>Fred Herbert</b>		Address <b>42 S. CAROLTON AVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THE CORONARY ARTERIES</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized atherosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>STATUS POST CEREBROVASCULAR ACCIDENT</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 11, 1956</b> to <b>April 12, 1956</b> , that I last saw the deceased alive on <b>April 11, 1956</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>HENRY ARMANAS</b>		DATE SIGNED <b>April 12, 1956</b>	
PHYSICIAN'S NAME (Type) <b>HENRY ARMANAS</b>		ADDRESS <b>Baltimore 23, Md.</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4-16-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHAS F. EVANS &amp; SON</b>		ADDRESS <b>118 W. MT. ROYAL AVE.</b>	
24a. REC'D BY REGISTRAR <b>W. J. JONES</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. JONES</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 15 1

3870

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8601 Richmond Circle</b>				d. STREET ADDRESS <b>8601 Richmond Circle</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mrs. Cora M. Reeves</b>				4. DATE OF DEATH Month Day Year <b>April 19 19 56</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1882</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James T. Moar</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Dodge</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. Albert M. Reeves, 8601 Richmond Circle</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.9</b> DUE TO <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cell bladder disease</b> (c) <b>6 mo</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , 19____, to <b>Apr 19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Apr 17</b> , 19 <b>56</b> , and that death occurred at <b>3 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>J. J. Kimzey</b> M.D. <b>Apr 19 1956</b> PHYSICIAN'S NAME (Type) <b>PRITZ J KIMZEY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/21/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Marford Road #14</b>				24a. REC'D BY REGISTRAR <b>APR 20 1956</b>			
				24b. REGISTRAR'S SIGNATURE <b>Dr. A. M. McCoy</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 20 1956  
DEPARTMENT OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03769

CERTIFICATE OF DEATH

Reg. Dist. No.

3871

1. PLACE OF DEATH o COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>2 month 4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>R</u> Last <u>Reeves</u>		4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1885</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractors</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George C. Reeves</u>		14. MOTHER'S MAIDEN NAME <u>Iida M. Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Elizabeth Reeves</u> Address <u>3402-39th Place</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro vascular accident</u> DUE TO <u>Arterio sclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>disease</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/17</u> , 19 <u>56</u> , to <u>4/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/21/56</u> , 19 <u>56</u> , and that death occurred at <u>11:00 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		DATE SIGNED <u>4/21/56</u>	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>		<u>Catonville, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-24-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. GASCH SON'S</u>		ADDRESS <u>HYATTSVILLE, MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>APR 23 1956</u>		24b. REGISTRAR'S SIGNATURE <u>E. Brumby</u>	

RECEIVED

APR 11 1964

BUTLER A. N.



3802

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 Meadowbrook One</u>		d. STREET ADDRESS <u>same</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Peter M. Reitz</u>		4. DATE OF DEATH Month Day Year <u>Apr 29 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	9. AGE (In years, months, days) <u>86</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wm. Reitz</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mrs Eva Mosberger</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Decomposition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vasc. Renal Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 10</u> , 1953, to <u>April 29</u> , 1956, that I last saw the deceased alive on <u>April 28</u> , 1956, and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William K. Gallagher</u> M.D.		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		DATE SIGNED <u>Baltimore - 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 1, 56</u>	<u>Salem Lutheran</u>	<u>Catonville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nab + Son</u>		24a. REC'D BY REGISTRAR DATE <u>5/3/56</u>	
ADDRESS <u>28</u>		24b. REGISTRAR'S SIGNATURE <u>T. J. ...</u>	

MEDICAL CERTIFICATION

CATONVILLE 28, MARYLAND

FREDERICK AND WADE AVENUES

MACNABB FUNERAL HOME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Deaths, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 7 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3803

## CERTIFICATE OF DEATH

03771

Item 2, Film G 125, 4/10/56

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>				c. LENGTH OF STAY IN 1b <b>6 WEEKS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>Box 167, Bishop St.</b> <b>QUINTY HOME</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARVEY EDEN REPP</b>				4. DATE OF DEATH Month Day Year <b>APRIL 4 1956</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-31-1881</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FOUNDRY</b>			
13. FATHER'S NAME <b>MONASSAH REPP</b>				14. MOTHER'S MAIDEN NAME <b>SARAH PFOUTZ</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Hospital Records Mt. Wilson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>OOZA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 MONTHS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <b>2-21-1956</b> to <b>4-4-1956</b> , that I last saw the deceased alive on <b>4-4-1956</b> , and that death occurred at <b>4:25 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.				Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) <b>WM. NEWCOMER, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>4/7/56</b>		<b>BEAVER DAM CEM</b>		<b>FREDERICK COUNTY MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<b>DD HARTZLER &amp; SONS</b>				<b>MD</b>		<b>Donny Newell</b>	
DATE				DATE		DATE	
<b>APR 6 1956</b>				<b>APR 6 1956</b>		<b>APR 6 1956</b>	



Reg. Dist. No. 33

St. Jacob's Kindergarten, New Freedom, Pa. DATE 4/13/56 Leicester & Bristol

VS. A13ME(S)  
SM 9/55

570-8115

1000

3825

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>715 Millen Road</b>		d. STREET ADDRESS <b>4110 Northern Parkway</b>	
3. NAME OF DECEASED (Type or print) <b>Mr. Harry Clermont Rivers Sr</b>		4. DATE OF DEATH <b>April 12 1956</b>	
5. SEX <b>male c</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>73 yrs</b>
11. BIRTHPLACE (State or foreign country) <b>Tareytown, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Augustus Rivers</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Stevenson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Anna R. Sommer, 715 Millen Road, #4</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>440.1</b> <b>Coronary occlusion</b> DUE TO <b>coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 19, 1956</b> to <b>April 12, 1956</b> ; that I last saw the deceased alive on <b>April 12, 1956</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/16/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Marford Road #14</b>		24a. REC'D BY REGISTRAR <b>APR 16 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Michael Brays</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3806 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

037754  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) c. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN lb <b>6 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>701 Eastern Blvd. Essex</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>701 Eastern Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leslie</b> Middle <b>Robertson</b> Last <b>Robertson</b>				4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1902</b>		9. AGE (In years last birthday) <b>53</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machine Shop</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Howard Robertson</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Foutch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-10-7992</b>		17. INFORMANT <b>James Wm. Nolen</b>		Address <b>701 Eastern Blvd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M B Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>				DATE SIGNED <b>4/17/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 18, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Rd., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>418 Eastern Blvd. Essex</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs Edith Shirley</b>	

RECEIVED

APR 10 1950

BUREAU V. 9

3807

## CERTIFICATE OF DEATH

Reg. Dist. No.

22

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>MERLE</b> Middle <b>H</b> Last <b>ROBINSON</b>		4. DATE OF DEATH Month <b>4</b> Day <b>2</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12.15.04</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARTENDER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>DARLINGTON, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HOWARD ROBINSON</b>		14. MOTHER'S MAIDEN NAME <b>ADA JONES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216098923</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Mt. Wilson, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FAR ADVANCED PULMONARY CAVITARY, TUBERCULOSIS</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3.23.1956</b> to <b>4.2.1956</b> , that I last saw the deceased alive on <b>4.2.1956</b> , and that death occurred at <b>2:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>4.2.56</b>			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		DATE SIGNED <b>4.2.56</b>	
PHYSICIAN'S NAME (Type) <b>WM. NEWCOMER, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>April 5, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Harford Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Harford Co, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. B. ...</b>		24a. REC'D BY REGISTRAR <b>...</b>	24b. REGISTRAR'S SIGNATURE <b>...</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1956

RECEIVED

## 3828 CERTIFICATE OF DEATH

Items 13, 14 Film 9196 4-20-56 e

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Maryland Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write OR and give nearest town)			
TOWN <u>Edgemere</u>				TOWN <u>Edgemere</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2433 Brannon Ave.</u>				STREET ADDRESS (If rural give location) <u>2433 Brannon Ave.</u>			
3. NAME OF DECEASED: (First) <u>Mollie</u>		(Middle) <u>T.</u>		(Last) <u>Rotan</u>		4. DATE OF DEATH: (Month) <u>April</u> (Day) <u>1</u> (Year) <u>1956</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Nov. 27. 1876</u>	
9. AGE last birthday: <u>79</u> yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>At home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>? Wissussek</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Herbert F. Rotan 2433 Brannon Ave.</u>			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4. Immediate cause (a) <u>Cerebral Hemorrhage</u>							<u>3 days</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertension C-V Disease</u>							<u>6 yrs</u>
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Apr. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr. 1</u> , 19 <u>56</u> , and that death occurred at <u>10:20 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>James V. Mims</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>520 20 St. Balto Md</u>		DATE SIGNED <u>4/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr. 3, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>APR 3 1956</u>		REGISTRAR'S SIGNATURE <u>Lawson L. Lacey</u>		24. FUNERAL DIRECTOR <u>Ullrich Funeral Home</u>		ADDRESS <u>2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR FOLDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 1957

100-100000

03778

3809  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cathering Robb Nursing Home 1105 Essex Rd.</b>		d. STREET ADDRESS <b>8807 Liberty Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AMELIA</b> Middle <b>LOUISE</b> Last <b>RUSSELL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> , Year <b>19 56</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1869</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John Glaser</b>		14. MOTHER'S MAIDEN NAME <b>Mary Piel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mrs. Frances R. Henry-7126 Dogwood Rd.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILAT. LOBAR PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARDIAC FAILURE GR II</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>APR 9, 1956</b> , to <b>APR 30, 1956</b> , that I last saw the deceased alive on <b>APR 30, 1956</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>RANDALLSTOWN, MD.</b> DATE SIGNED			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. <b>RANDALLSTOWN, MD.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/2/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS <b>Bethesda, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>5/2/56</b>
		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 2 1956

RECEIVED



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03779

3660

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>DUNDALK</u>		<u>14 YRS</u>		TOWN <u>DUNDALK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>6900 SOLLERS PT. RD.</u>				<u>6900 SOLLERS PT. RD.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>ROY FRANKLIN SANDRIDGE, SR.</u>				<u>4-16-56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>APR. 16, 1912</u>	<u>44</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>LEADER</u>		<u>STEEL MILL</u>		<u>VIRGINIA</u>		<u>U. S. A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>ERNEST R. SANDRIDGE</u>				<u>LUCY WALTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>219-05-0096</u>		<u>EDNA U. SANDRIDGE - Sister</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) <u>Cancer of Rectum</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Metastasis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>April 1956</u>		<u>Same - Colon - 1955</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 20, 1956</u> to <u>April 20, 1956</u> , that I last saw the deceased alive on <u>April 16, 1956</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. B. Davis</u>				DATE SIGNED <u>APR 20 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-20-56</u>		<u>DAK LAWN</u>		<u>BALTO. CO. MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>APR 20 1956</u>		<u>M. M. Kelly, Jr.</u>		<u>Walter J. Kelly, Jr.</u>		<u>Walter J. Kelly, Jr.</u>	

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

APR 2

U.S. DEPT. OF JUSTICE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The ☐ requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly shall be detached for use as a burial transit permit.

V5 A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 3810 CERTIFICATE OF DEATH

03780  
Reg. Dist. No. 29

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Monkton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Corbett Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Monkton</u> STREET ADDRESS (If rural give location) <u>Rural - Monkton</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George Arthur Saportas</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4-14-56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>4-8-1904</u>
9. AGE last birthday <u>52</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>52</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horseman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>horse training</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Saportas</u>		14. MOTHER'S MAIDEN NAME <u>Regina Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-22-7464</u>	
17. INFORMANT & ADDRESS <u>Mrs. Mildred P. Saportas, Monkton, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>		10. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. ??</u> <u>?</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 1954</u> to <u>14 APR. 1956</u> , that I last saw the deceased alive on <u>14 APR. 1956</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. SIGNATURE <u>Thos. A.E. Moreley, M.D.</u> ADDRESS (Street, city, town, state) <u>Jarrettsville, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4-16-56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. James Episcopal</u>		LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>4-17-56</u>		REGISTRAR'S SIGNATURE <u>M. Elizabeth Gorsuch</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		ADDRESS <u>Sparks, Md.</u>	

BUREAU V. S.

APR 10 1956

RECEIVED

3811

CERTIFICATE OF DEATH

03781

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PARADISE HOME</u>				e. STREET ADDRESS <u>3512 Frederick Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>BERTHA E. SCHUELMANN</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1864</u>	9. AGE (In years last birthday) <u>91</u> yrs	10. UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Residence</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>CHARLES C. SCHUELMANN</u>			
14. MOTHER'S MAIDEN NAME <u>ANNA E. WENDENOTH</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Miss. EDNA M. McALLISTER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis C.V.D.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan. 1944</u> to <u>Apr 30, 1956</u> , that I last saw the deceased alive on <u>Apr 30, 1956</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>J. C. POUND</u> M.D.				<u>3325 Frederick Ave</u> <u>5/2/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>MAY 3-1956</u>		<u>London Park Cem.</u>		<u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Truman Schwal</u>				ADDRESS <u>3512 Frederick Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>5/4/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>			

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BUREAU V. E.

MAY 4 1956

RECEIVED  
MAY 4 1956

## 3812 CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>ROSEDALE</u>		<u>About 3 mos.</u>		TOWN <u>ROSEDALE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>7925 Dalrose Ave.</u>		STREET ADDRESS (If rural give location) <u>7925 DALROSE AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>EDWARD GEORGE SCHMAUS</u>				<u>April 2 1956.</u>			
5. SEX.		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>Jan. 29, 1891.</u>	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>65 yrs.</u>		<u>Retired</u>		<u>Baltimore, Md.</u>		<u>Same.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>JOHN SCHMAUS</u>				<u>ANNA FUHRER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
<u>NO</u>				<u>Elizabeth Schmaus Same.</u>			
15. MEDICAL CERTIFICATION							
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Hypertensive Cardio Vascular Disease.</u>			
ANTECEDENT CAUSE (S)				(B) <u>Intermittent</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>Cerebral Thrombosis</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
				INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>54</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>56</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Richard J. Janowski</u>		<u>2711 Eastern Ave.</u>		<u>4/4/56</u>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4-5-56</u>		<u>SACRED HEART CEM.</u>		<u>7401 GERMAN HILL RD., MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>April 4, 1956</u>		<u>A. W. H. H. H. H.</u>		<u>Charles S. Giller 901 S. CONKLING ST. BALTO., MD.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2111 E. 1st Ave.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3813

## CERTIFICATE OF DEATH

Reg. Dist. No.

03783

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. LENGTH OF STAY IN 1b <b>Middle River</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>60 Dogwood Drive</b>				d. STREET ADDRESS <b>60 Dogwood Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>ORRIE</b> Middle <b>E.</b> Last <b>SEARS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1882</b>	9. AGE (In years last birthday) <b>73</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Beaugard Sears</b>				14. MOTHER'S MAIDEN NAME <b>Lillian B. Trott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-01-5462</b>		17. INFORMANT <b>Clara N. Shipley, 60 Dogwood Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Hemiplegia--right - obesity</b>						INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>10 Yrs.</b> <b>10 Yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 19, 1956</b> to <b>April 29, 1956</b> , that I last saw the deceased alive on <b>April 29, 1956</b> , and that death occurred at <b>7:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>413 Eastern Avenue Baltimore 21, Md.</b> DATE SIGNED <b>April 30, 1956</b>							
ACTUAL SIGNATURE <b>Harry B. Smith</b>				M.D. <b>413 Eastern Avenue</b>			
PHYSICIAN'S NAME (Type) <b>Harry B. Smith, M. D.</b>				<b>Baltimore 21, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/2/56</b>		22c. NAME OF CEMETERY <b>Baldwin Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Severn Crossroads, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Coates Inc</b>				ADDRESS <b>1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>5/2/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. Edith Thorley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 2 1956

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

03784

Reg. Dist. No. 38

3814

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		LENGTH OF STAY (in this place) <b>MARYLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>500 Bosley Ave.</b>				STREET ADDRESS (If rural give location) <b>500 Bosley Ave.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>CHARLES</b>		(Middle) <b>WILSON</b>		(Last) <b>SHADE</b>		(Month) <b>April</b> (Day) <b>23</b> (Year) <b>19 56</b>	
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>Mar. 5, 1893</b>		<b>9. AGE last birthday</b> <b>63</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Foreman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Meat Packers</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Penna.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>Robert Shade</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Fetter</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Laura Shade-500 Bosley Ave.</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <b>UREMIC POISONING</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3/56</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>The kidneys &amp; nephritis</b>						<b>1952</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1949, 19, to 4/23, 1956, that I last saw the deceased alive on 4/23, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>W. K. Karpman</i>		<b>M.D.</b> <i>4331 Haywood Rd</i>		<b>DATE SIGNED</b> <i>4/21/56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>		<b>DATE THEREOF</b> <b>4/27/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Green Mount Crematory</b>		<b>LOCATION (City, town, or county)</b> <b>Balto., Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>M. L. Kray</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Wm. J. Dickner &amp; Sons</i>		<b>ADDRESS</b> <i>Balto. Md.</i>	

BUREAU Y. M. M.

MAY 23 1956

RECEIVED  
MAY 23 1956

3661

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Dundalk</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Dundalk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Baltimore Ave.</u>				STREET ADDRESS (If rural give location) <u>100 Baltimore Ave.</u>			
3. NAME OF DECEASED:		(First) <u>CONRAD</u>		(Middle) <u>HENRY</u>		(Last) <u>SHANAWOLF</u>	
(Type or Print)							
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>March 26, 1880</u>	
						9. AGE last birthday: <u>76</u> yrs. Months: Days: Hours: Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Jewelry</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>? Shanawolf</u>				14. MOTHER'S MAIDEN NAME: <u>Christina ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>S A W</u>				16. SOCIAL SECURITY NO.: <u></u>			
				17. INFORMANT & ADDRESS: <u>Mrs. Herman Auvil 5469 Dunhaven Road-22</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Cerebral Occlusion</u>							
Antecedent causes (s) (b) <u>Arterio Sclerotic H.D.</u>							
DISEASES OR CONDITIONS, IF ANY, giving rise to the above cause stating the underlying cause last. (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u></u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1</u> 19 <u>86</u> , to <u>4-24</u> , 19 <u>87</u> , that I last saw the deceased alive on <u>4-10</u> 19 <u>86</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
SIGNATURE OF REGISTRAR		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Jack E. Collins, M.D.</u>		<u>April 24, 1986</u>		<u>2 Kenilworth</u>		<u>Balt 22 Md 4-24-86</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>April 24-1986</u>		<u>William M Kelly</u>		<u>Ullrich Funeral Home</u>		<u>2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR FINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*(Faint handwritten notes at the bottom of the page)*

... 1911

BUREAU V. 8

APR 26 1956

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## CERTIFICATE OF DEATH

Reg. Dist. No.

30

3815

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklinton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklinton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1516 Saint Agnes Lane</u>				d. STREET ADDRESS <u>1516 Saint Agnes Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Freda</u> Middle <u>R.</u> Last <u>Sieck</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22, 1888</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. County Md.</u>	
13. FATHER'S NAME <u>Frederick Reitz</u>				14. MOTHER'S MAIDEN NAME <u>Helen Mahlman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address <u>Mr A. Fred Sieck, 1516 St Agnes Lane.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>44+X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular - senes</u> DUE TO (c) <u>10 years</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. p.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>4/29</u> , 19 <u>47</u> , to <u>4/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-12</u> , 19 <u>56</u> , and that death occurred at <u>9:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Scheye</u> M.D.				ADDRESS (Street, city or town, state) <u>3921 EDMONDSON AVE. BALTIMORE 29, MD.</u>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Violetville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harriet H. Witke</u>				ADDRESS <u>101 Edmondson Ave.</u>		24a. REC'D BY REGISTRAR <u>U. E. Harry</u>	
				DATE <u>10-18-56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 18 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor of the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3816 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03787

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Loch Raven Reservoir</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---		d. STREET ADDRESS <b>5508 Lombardy Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VINCENT</b> Middle <b>M</b> Last <b>SISK</b>		4. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1874</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore &amp; Ohio R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Sisk</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Crowley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT <b>Mrs. Henry F. Ullrich</b>		Address <b>5508 Lombardy Place</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING, FOUND DROWNED</b> <b>4227</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>PAUL F. GUERIN</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-28-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. H. Meador Son 805 N. Calvert St.</b>		24a. REC'D BY REGISTRAR <b>April 28 1956 R. W. Mabel Gray</b>	
24b. REGISTRAR'S SIGNATURE			

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BUREAU W. A.

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3817

## CERTIFICATE OF DEATH

03788  
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>26 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>4040 Edgewood Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>DAVID ( DANIEL SULLIVAN ) SMULLIAN</b>				4. DATE OF DEATH Month Day Year <b>April 27 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1893</b>		9. AGE (In years last birthday) yrs. <b>62</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Racing Association</b>		11. BIRTHPLACE (State or foreign country) <b>Waterford, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Sullivan</b>				14. MOTHER'S MAIDEN NAME <b>Reba Jacobson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>218-03-1615</b>		17. INFORMANT Address <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260x</b> (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1</b> 19 <b>56</b> , to <b>April 27</b> 19 <b>56</b> , that death was the result of <b>arteriosclerotic cardiovascular disease</b> , and that death occurred at <b>7:10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Francis G. Dickey</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>4/27/56</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>FRANCIS G. DICKEY, M.D., Chief, Medical Service</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-29-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Rosedale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>See Burial &amp; Bur. Inc.</b> ADDRESS <b>Md.</b> <b>Sol Levinson &amp; Bros., 1126 W. North Ave. Baltimore</b>				24. REG'D BY REGISTRAR <b>4-29-56</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Lucker</b>	

RECEIVED  
APR 1956  
BUREAU V. 8

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03789

## 3818 CERTIFICATE OF DEATH

Item 5: Hickner's statement 4-25-56L

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Balto.</b>		STATE <b>MARYLAND</b>		STATE <b>Va.</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		TOWN <b>Tye River</b>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>CHARLIE WALKER SPENCER</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>April 16, 19 56</b>			
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>Nov. 7, 1879</b>		<b>9. AGE last birthday</b> <b>76</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Car Repairman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Railroad</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>Walter Spencer</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Wallie Boland</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>719-03-8244</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. William Fogle-4514 Dunland Rd.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A)				<b>Cerebral thrombosis</b>			
ANTECEDENT CAUSE(S) DUE TO				<b>Arteriosclerosis</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>Hemiplegia</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>March 20, 19 56</b> <b>to</b> <b>April 16, 19 56</b> <b>that I last saw the deceased alive on</b> <b>April 16, 19 56</b> <b>and that death occurred at</b> <b>3:30 P.M.</b> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <b>Louis R. Mason M.D.</b> <b>ADDRESS (Street, city, town, state)</b> <b>4335 Park Heights Ave. Baltimore 4-1756</b> <b>DATE SIGNED</b> <b>4-17-56</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Removal</b>		<b>DATE THEREOF</b> <b>4/18/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Amherst Cem.</b>		<b>LOCATION (City, town, or county)</b> <b>Amherst, Va.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>W. E. Hany</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. J. Ticker</b>			
<b>DATE</b>				<b>ADDRESS</b> <b>Louis-Richards</b>			

BUREAU V. S.

APR 18 1956

RECEIVED







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film 105 1-12-56 at

3820

CERTIFICATE OF DEATH

03791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>		c. LENGTH OF STAY IN 1b <b>8 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Rural Pikesville Baltimore 5</b> <b>506 N. Milton Avenue</b> <b>602 Careysbrook Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Leo</b> Last <b>Starr</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 10, 1887</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dennis Starr</b>		14. MOTHER'S MAIDEN NAME <b>Cathrine Hyland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>214-34-3550</b>	
17. INFORMANT Address <b>Pikesville</b> <b>James R. Athon, 602 Careysbrook Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>years</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>about 2 wk</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>about</b> , 19 <b>54</b> , to <b>April 6</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 5</b> , 19 <b>56</b> , and that death occurred at <b>11 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. H. Hightstein</b>		ADDRESS (Street, city or town, state) <b>888 W. Lombard St</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>G. H. HIGHTSTEIN M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 9, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Hightstein</b>		24a. REC'D BY REGISTRAR <b>Dorothy L. Hightstein</b> 24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

APR 10 1900

RECEIVED

Item 12, Filmm, 3-2-56 et

3821

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2806 Glendale Avenue</b>		d. STREET ADDRESS <b>2806 Glendale Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Mrs. Anna M. Steiner</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1868</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ferdinand Salzman</b>		14. MOTHER'S MAIDEN NAME <b>Elinor Fritzenwanken</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Earl Rullman, 2806 Glendale Avenue #14</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b> <b>4-22-56</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-23-</b> , 1947, to <b>4-22-</b> , 1956, that I last saw the deceased alive on <b>4-22-</b> , 1956, and that death occurred at <b>4:40 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Emmett R. Rany</b> M.D.		ADDRESS (Street, city or town, state) <b>2117 Belair Rd</b> DATE SIGNED <b>4-24-56</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/25/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Marford Road #14</b>		24a. REC'D BY REGISTRAR DATE <b>4/26/56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1911

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03793

## CERTIFICATE OF DEATH

3822

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville 38 Md</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Spring Grove State Hospital</b>				e. STREET ADDRESS <b>6810 Dogwood Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Edward Strong</b>				4. DATE OF DEATH Month Day Year <b>April 1, 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 3, 1903</b>	9. AGE (In years last birthday) <b>53</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>James E. Strong</b>			
14. MOTHER'S MAIDEN NAME <b>Annie ?</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Records: Spring Grove State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia, infarctive</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>C.N.S. Les</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>  <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Mar. 12, 19 56</b> to <b>Apr. 1, 19 56</b> that I last saw the deceased alive on <b>Mar. 31, 19 56</b> , and that death occurred at <b>2:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b> DATE SIGNED <b>4/1/56</b> ACTUAL SIGNATURE <b>T. Glyne Williams</b> M.D. <b>Catonsville 28, Md.</b> PHYSICIAN'S NAME (Type) <b>T. Glyne Williams, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/4/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Worth Amason</b>				ADDRESS <b>4600 Liberty Hgts. Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>4/4/56</b>	
24b. REGISTRAR'S SIGNATURE <b>T. E. Jones</b>							

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1000

MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

BUREAU V. S.

MAY 3 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03795

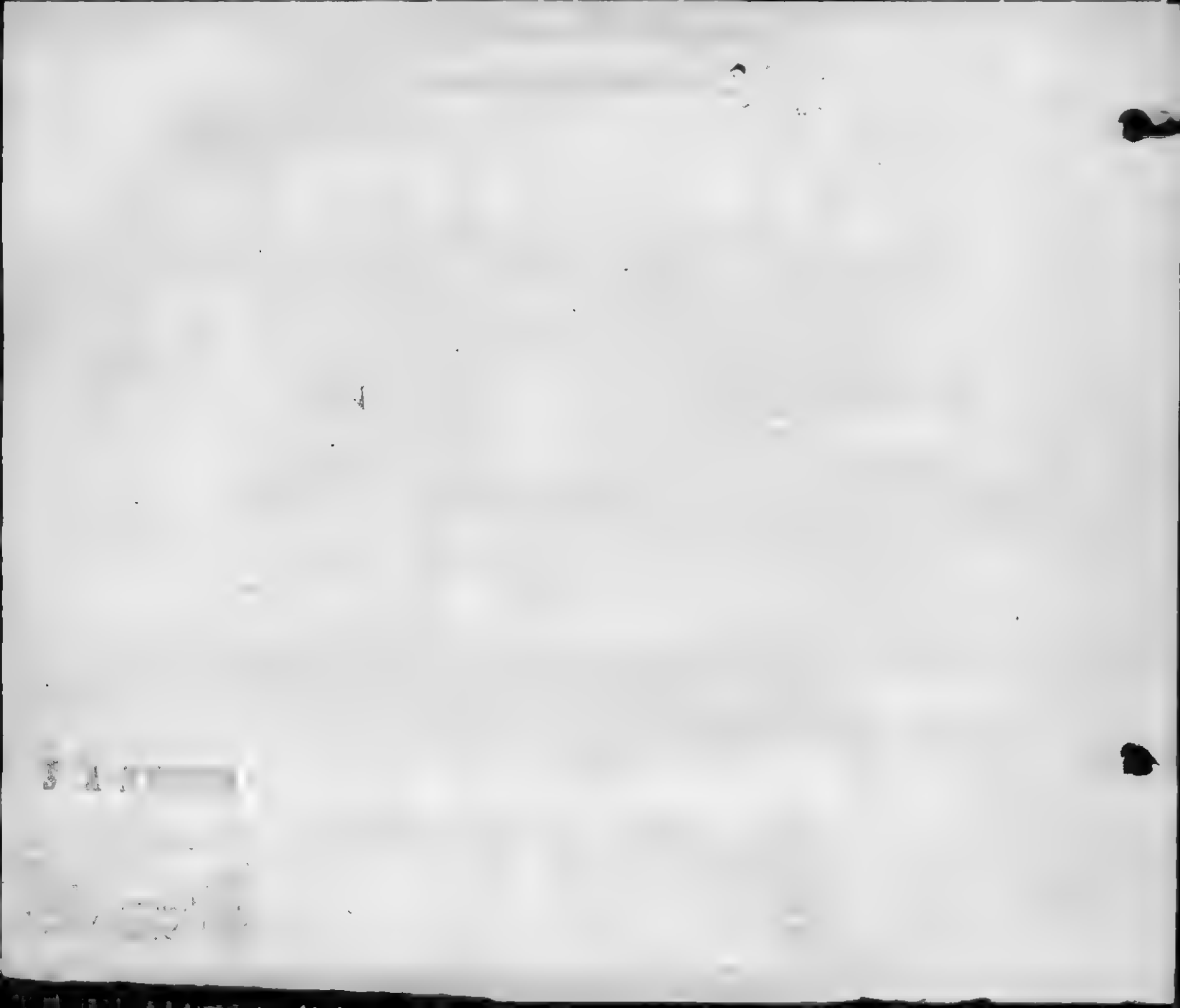
3663

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 9, filed 1954-16-26 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>2 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK 22</u>			
HOSPITAL OR INST TUTION OR STREET ADDRESS <u>7903 ST. GREGORY DRIVE</u>				STREET ADDRESS (If rural give location) <u>7903 ST. GREGORY DRIVE</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>MARK</u> (Middle) <u>HAMMELL</u> (Last) <u>TABLER</u>				4. DATE OF DEATH (Month) <u>APR.</u> (Day) <u>9</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug 22, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NELSON TABLER</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE HICKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>75-16-9573</u>		17. INFORMANT & ADDRESS <u>MYRTLE A. TABLER - SAME</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>						1-2 hours	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Asthma and Emphysema</u>							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 25, 1956</u> to <u>April 9, 1957</u> , that I last saw the deceased alive on <u>April 11, 1957</u> , and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Ravil Owens</u>				ADDRESS (Street, city, town, state) <u>919 D St. Bg 170. 19 Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>ROSEDALE</u>		LOCATION (City, town, or county) (State) <u>MARTINSBURG, W. VA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Tom Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Porter Dondy</u>		ADDRESS	
DATE <u>11-12-56</u>							



MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

U. S. A.

1917

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 13, 14, Film 195 4-6-56 et  
3824  
CERTIFICATE OF DEATH

03797

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3025 Linwood Avenue #14</b>				d. STREET ADDRESS <b>3025 Linwood Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>MARY MARGARET TAYLOR</b>				4. DATE OF DEATH Month <b>APRIL</b> 1st <b>1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1885</b>		9. AGE (In years last birthday) <b>70</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Clara (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Emma Mc Kean, 4921 Denmore Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>445X Arteriosclerosis - Hypertensive</b> DUE TO <b>cardio-vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/25</b> , 19 <b>55</b> , to <b>Jan 28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1/28</b> , 19 <b>56</b> , and that death occurred at <b>14570</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Nathan Janney</b> M.D.				ADDRESS (Street, city or town, state) <b>7101 Harford Rd. Balto. 14, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Nathan Janney</b>				DATE SIGNED <b>4/2/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/4/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>				24a. REC'D BY REGISTRAR DATE <b>Apr. 3, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. L. M. Bacon</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 4 1964  
BUREAU Y. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The information copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 TOM

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 3672 CERTIFICATE OF DEATH

03798

Reg. Dist. No. 47

1. PLACE OF DEATH <i>Baltimore County</i>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>MARYLAND</i>		MARYLAND		STATE <i>MARYLAND</i> COUNTY <i>1</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Arbutus</i>		<i>64 yrs.</i>		TOWN <i>BALTO. at Arbutus</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Residence - Locust Ave.</i>				STREET ADDRESS (If rural give location) <i>Locust Ave.</i>			
3. NAME OF DECEASED (Type or Print) <i>Marie Adelaide Teipe</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>April 18, 1956</i>			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>		8. DATE OF BIRTH <i>JAN. 24, 1892</i>	
				9. AGE last birthday <i>64</i> yrs.		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Billing Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>VA. CAROLINA CO.</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John A. Teipe</i>				14. MOTHER'S MAIDEN NAME <i>Isabelle A. Gooking</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-07-7043</i>		17. INFORMANT & ADDRESS <i>Locust Ave. Miss. CLARA S. Teipe (27)</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Carcinoma - Origin unknown</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>with multiple metastases -</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Pathologic fracture right thigh</i>				<i>Jan 27-56</i>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Apr 18th</i> , 19 <i>08</i> , to <i>Apr 18th</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Apr 18th</i> , 19 <i>56</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Frederick V. Beeler</i>		ADDRESS (Street, city, town, state) <i>M.D. 1014 Francis Ave - Balto 27 - Md.</i>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4-21-1956</i>		NAME OF CEMETERY OR CREMATORY <i>New Cathedral CEM. BALTO. Md.</i>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Dr. Geo. S. M. Luffey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>G. Freeman &amp; Son</i>		ADDRESS <i>3512 F. Edmunds Cir. (29)</i>	

APR 20 1956

EDWARD A. S.

APR 1

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03799

30

## 3825 CERTIFICATE OF DEATH

Reg. Dist. No. ....

Date of Death: April 28, 1956

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SPACEDOWN POINT</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ATON RIDGE HOME</u>		STREET ADDRESS (If rural give location) <u>306 D ST.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>SARAH</u> (Middle) <u>F.</u> (Last) <u>THOMAS</u>		(Month) <u>2</u> (Day) <u>28</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.H.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>5/20/1886</u>
9. AGE last birthday <u>69</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-28-0665</u>	
17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>			<u>2 hrs</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis gen</u>			<u>Unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Cerebral Disturbance 7 abd</u>			<u>48 hrs</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 13</u> , 19 <u>56</u> , to <u>4/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/26</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>Cory R. Rount 8 M.D.</u>		ADDRESS (Street, city, town, state) <u>4605 Edmond Ave</u>	
DATE <u>4/27/56</u>		DATE SIGNED <u>4/27/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-28-56</u>	NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	LOCATION (City, town, or county) <u>Belts. MD</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>V. E. Harris</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Burke Bradley, Belts, MD</u>	ADDRESS

RECEIVED  
APR 11 1964  
BUNNELL R. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3826

CERTIFICATE OF DEATH

Reg. Dist. No.

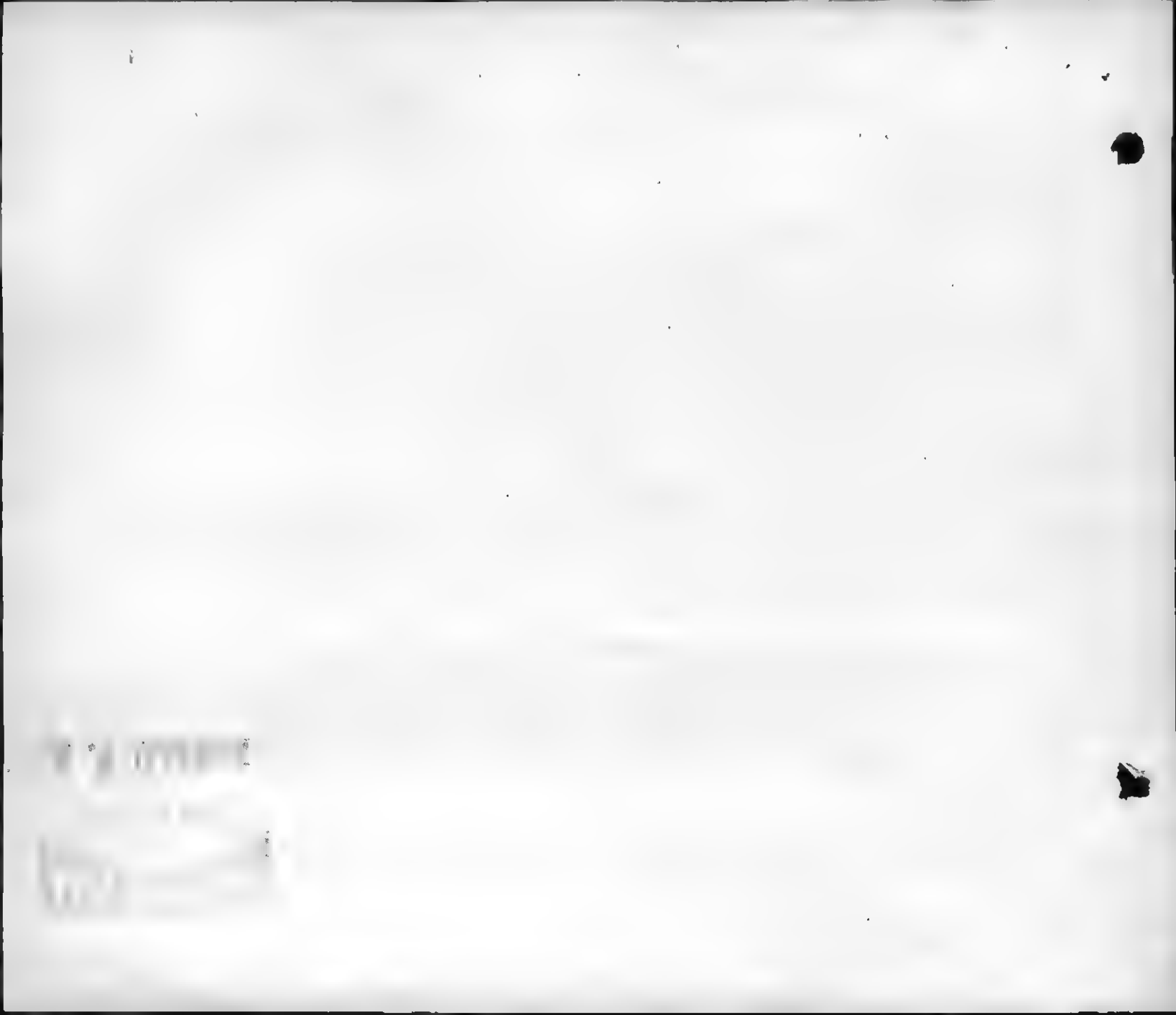
03800

45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTO</b>		MARYLAND		STATE <b>MD</b>		COUNTY <b>BALTO</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<b>ESSEX (21)</b>		<b>6 WK.</b>		<b>DUNDALK (22)</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>1114 HALL HOME</b>				<b>7829 WISE AVE</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<b>NAOMI BURROWS TITUS</b>				<b>4-16-1958</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>F.</b>	<b>W.</b>	<b>MARRIED</b>	<b>FEB. 6, 1895</b>	<b>71</b> yrs.	<b>Months</b>	<b>Days</b>	<b>Hours</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<b>HOUSEWIFE</b>						<b>W. VA.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME:			
<b>LEVI BURROWS</b>				<b>SARAH JANE WRIGHT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
<b>NO</b>				<b>JESSE L. TITUS - 21921E</b>			
16. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)				DUE TO			
<b>Carcinoma of gall bladder</b>				<b>6 months</b>			
ANTECEDENT CAUSE (B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
				<b>Carcinoma of gall bladder</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>March 19, 1958</b> to <b>April 16, 1958</b> that I last saw the deceased alive on <b>April 12, 1958</b> , and that death occurred at <b>11 55 A.M.</b> from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<b>A. L. Kolodny MD</b>				<b>Baltimore 71, Md</b>		<b>4/16/58</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<b>BURIAL</b>				<b>4-27-58</b>		<b>MEADINKRIVE</b>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<b>April 20 1958</b>				<b>Mrs. Edith Hurlings</b>		<b>1114 Hall Home</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03801

3827

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 2, Film 196 4-23-56 et

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Lutherville		LENGTH OF STAY (in this place) 2 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS College Manor				STREET ADDRESS (If rural, give location) 3516 Erdman Ave.	
3. NAME OF DECEASED (First) Anna (Middle) K. (Last) Tochterman		4. DATE OF DEATH April 11 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH July 11, 1888	9. AGE last birthday 67 yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Robert Fries		14. MOTHER'S MAIDEN NAME Mary Sutter		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS Edward S. Tochterman 3516 Erdman Ave.	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <del>Heart disease</del> Central arteriosclerosis					3 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <del>Chronic bronchitis, ischaemic heart disease</del>					1 yr
(c) Malnutrition					months
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 8, 1954, to April 11, 1956, that I last saw the deceased alive on April 11, 1956, and that death occurred at 7:50 P.M., from the causes and on the date stated above.					
SIGNATURE Ernest C. Brown Jr.		(Degree or title) M.D.		ADDRESS 401 N. Calvert St. DATE SIGNED 4/13/56	
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF April 14, 1956		NAME OF CEMETERY OR CREMATORY Oak Lawn	
DATE REC'D BY LOCAL REG. April 14, 1956		REGISTRAR'S SIGNATURE R. W.		24. FUNERAL DIRECTOR Lilly & Zeiler Inc., 403 S. Wolfe St.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3828

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>1301 St. Paul Street</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>S.</u> Last <u>TUDOR</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1896</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR: Months <u>24</u> Days <u>19</u> Hours <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment House</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward W. Tudor</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>212-14-1568</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SQUAMOUS CELL CARCINOMA OF TONGUE</u> <u>141X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 2, 1955</u> to <u>April 24</u> , 19 <u>56</u> and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Francis G. Dickey</u> M.D. <u>4/24/56</u>			
22. PHYSICIAN'S NAME (Type) <u>FRANCIS G. DICKEY, Chief Medical Service, VAH, FORT HOWARD, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-28-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight Inc</u> ADDRESS <u>Wm Cook-Blight, Inc., 6009 Harford Rd., Balto., Md.</u>		24a. REC'D BY REGISTRAR <u>4/27/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Lawson L. Lister</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 1950

LIBRARY U. S.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3673

## CERTIFICATE OF DEATH

03803

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Balto.</b>		STATE <b>Md.</b>		COUNTY <b>Balto.</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>5532 Link Ave.</b>				STREET ADDRESS (If rural give location) <b>5532 Link Ave.</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>EDYTHE TURNER</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>April 3, 1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>Dec. 10, 1888</b>		9. AGE last birthday <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George W. Dennis</b>				14. MOTHER'S MAIDEN NAME <b>Caroline P. Hellen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT & ADDRESS <b>Mr. Albert E. Lurner-5532 Link Ave. Arbutus, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)						<b>Coronary thrombosis</b> <b>Arteriosclerotic Hypertensive CVD</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>4/1</b> 19 <b>56</b> , to <b>4/3</b> 19 <b>56</b> , that I last saw the deceased alive on <b>4/3</b> 19 <b>56</b> and that death occurred at <b>7:08 P.</b> M. from the causes and on the date stated above.							
SIGNATURE <b>Herbert J. Lurichas</b>		M.D. <b>5305 East Drive Arbutus</b>		ADDRESS (Street, city, town, state) <b>Arbutus</b>		DATE SIGNED <b>4/5/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>4/6/56</b>		NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
24. REC'D BY REGISTRAR <b>DATE</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Lickness</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickness &amp; Sons - Baltimore</b>		ADDRESS	

10-11-1944

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Iter Film 19 5-2-56

3829

## CERTIFICATE OF DEATH

03804

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood Maryland</b>				c. LENGTH OF STAY IN 1b <b>3 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sorenson Nursing Home</b>				e. STREET ADDRESS <b>unknown</b>			
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>M.</b> Last <b>Walker</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1866</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>25</b> Days <b>1956</b> Hours <b>90</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Albert Walker -328 Rossiter Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute embolism</b>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <b>Myocarditis chronic with weakening</b> 5 years	
DUE TO							
(c) <b>Hypertrophy myocardium with failure</b> 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Arteriosclerosis generalized.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>none</b> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>no injury</b>	
				20f. (City or town) <b>no injury</b>		(County) (State)	
21. I certify that I attended the deceased from <b>February 7, 1956</b> , to <b>April 25, 1956</b> , that I last saw the deceased alive on <b>April 17, 1956</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James Graham Marston, M.D.</b>						ADDRESS (Street, city or town, state) <b>516 Cathedral Street Balto Md</b>	
PHYSICIAN'S NAME (Type) <b>James Graham Marston, M.D.</b>						DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>April 28, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemt. Balto. Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A Moran</b>				ADDRESS <b>3000 E BALTO ST.</b>		24. REC'D BY REGISTRAR <b>APR 30 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

RECEIVED  
APR 22 1966  
BUREAU Y. A.

3830

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>55 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E.</u> Last <u>WALLACE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23, 1920</u>	
9. AGE (In years last birthday) <u>35</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (Tire man)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(Air-craft) Government</u>		11. BIRTHPLACE (State or foreign country) <u>McKinley, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Wallace</u>			
14. MOTHER'S MAIDEN NAME <u>Eliza MN: Wallace</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <input checked="" type="checkbox"/> <u>WW II</u>			
16. SOCIAL SECURITY NO. <u>214-16-1876</u>				17. INFORMANT <u>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FIBROSIS</u> DUE TO <u>CORONARY ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED SARCOIDOSIS</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>March 6, 1956</u> to <u>April 30, 1956</u> . I have not seen the deceased since <u>April 30, 1956</u> , and that death occurred at <u>6:00 A. M.</u> from the causes and on the date stated above.			
21. ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u>				21. DATE SIGNED <u>5/1/56</u>			
21. PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moses Cooper Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson, 34 Lafayette Ave., Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

MAY 4 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03806

## 3831 CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Balto.</b>		STATE <b>Md.</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Catonsville</b>				TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>122 Smithwood Ave.</b>				STREET ADDRESS (If rural give location) <b>2303 Riggs Ave.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>FRANCIS McDOWELL WARREN</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>April 15, 1956</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>Jan. 27, 1909</b>	<b>9. AGE last birthday</b> <b>47</b> yrs.	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Welder</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Welding (Elec)</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>John P. Warren</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Lankford Warren</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Thelma Warren-2303 Riggs Ave.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <b>CARCINOMATOSIS - GENERALIZED</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>CARCINOMA - PANCREAS</b>				<b>3-4-10-11-12</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from FEB 15, 1956, to APRIL 15, 1956, that I last saw the deceased alive on APRIL 15, 1956, and that death occurred at 10:50 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Edmondson</i> M.D. 3803				<b>DATE SIGNED</b> <b>4/17/56</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>4/18/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Woodlawn Cem.</b>		<b>LOCATION (City, town, or county)</b> <b>Woodlawn, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>F. E. Tamm</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Edmondson</i>		<b>ADDRESS</b> <b>Baltimore</b>	
<b>DATE</b>							

BUREAU V. S.

APR 15 1900

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03807

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> c. LENGTH OF STAY IN 1b <u>16 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home, 3400 Hopkins Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> d. STREET ADDRESS <u>3400 Hopkins Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MARGARET</u> Middle <u>Martha</u> Last <u>WEIDENHAMMER</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>19</u> Year <u>19 56</u>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MAY 9, 1915</u>		<b>9. AGE</b> (In years last birthday) <u>40 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>19</u> Hours <u>56</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Domestic</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Adam Strumsky</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>MARGARET GREIFZU</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> (If yes, give year or dates of service) <u>NONE</u>		<b>17. INFORMANT</b> Address <u>CHARLES WEIDENHAMMER 3400 Hopkins Ave.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to hanging</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gunshot wound of left breast</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Hung self from rafter after shooting self.</u>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				<b>20f. (City or town)</b> <u>Partial Halethorpe Balto.</u> (County) (State) <u>Maryland</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .											
<b>ACTUAL SIGNATURE</b> <u>William V. Lovitt, Jr.</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DATE SIGNED</b> <u>4/19/56</u>		
<b>EXAMINER'S NAME (Type)</b> <u>William V. Lovitt, Jr., M.D.</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>		
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>4-23-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>NEOLITHEDAL</u>				<b>22d. LOCATION (City, town, or county)</b> <u>BALTIMORE</u> (State) <u>MARYLAND</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Gorge L. Schwalb</u> ADDRESS <u>2101 Redwood Ave. Md.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DATE</u>			<b>24b. REGISTRAR'S SIGNATURE</b> <u>Dr. Geo. M. Luff</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, giving the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the Care Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S.

x

James V. Smith

3832

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. NAME OF DECEASED (Type or Print) <b>ERNEST PHILLIP WESTERLUND</b>			2. DATE OF DEATH <b>APRIL 3, 1956</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>BALTO. Co. MD.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>427 REGISTER AVE.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>TOWSON</b>		
c. Length of stay in Baltimore Co. <b>27 Yrs</b>			d. STREET ADDRESS (If rural, give location) <b>427 REGISTER AVE.</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAY 1, 1889</b>	9. AGE (In years last birthday) <b>66</b>	10. Under 1 Year Months: Days <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DEPT. CHIEF</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>WESTERN ELECT.</b>		
11. BIRTHPLACE (State or foreign country) <b>CHICAGO ILL.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>CARL JOHAN WESTERLUND</b>			14. MOTHER'S MAIDEN NAME <b>ANNA CARLSON</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>215-03-9533</b>		
17. INFORMANT <b>MRS. ADELINE WESTERLUND</b>			ADDRESS <b>SPRING</b>		

18. <b>102X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHIOGENIC CARCINOMA</b>	CAUSE OF DEATH <b>BRONCHIOGENIC CARCINOMA</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 MONTHS</b>
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ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

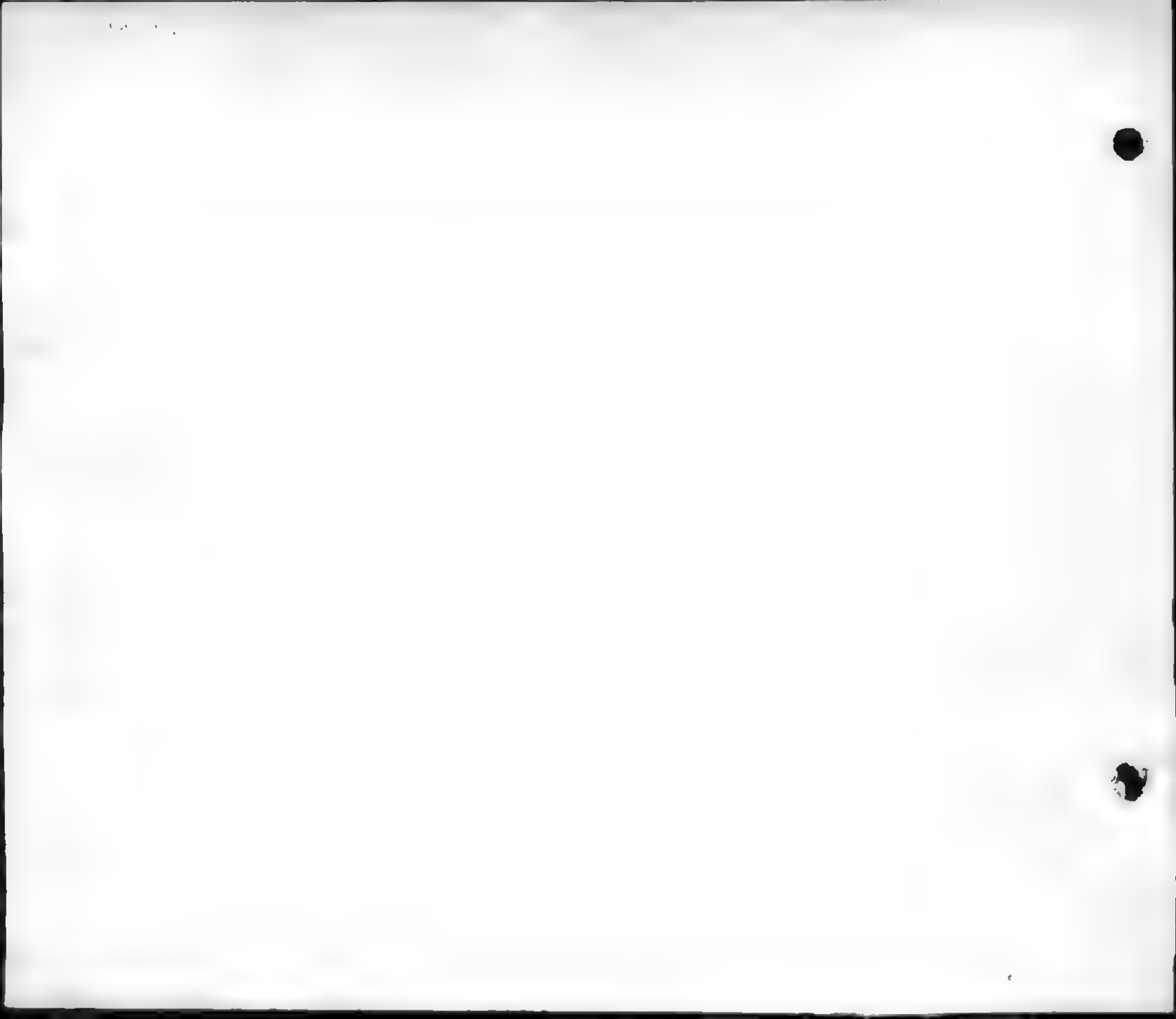
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. TIME (Month) (Day) (Year) (Hour) OF INJURY	21b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21c. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>23-January</b> 19 <b>56</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4-April</b> 19 <b>56</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.				
23a. SIGNATURE <b>Charles E. Edmunds</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	23b. ADDRESS <b>2746 The Alameda</b>	23c. DATE SIGNED <b>5-April-1956</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>4-6-1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEM.</b>		
24d. LOCATION (City, town, or county) (State) <b>BALTO. Co. MD.</b>		25. FUNERAL DIRECTOR <b>H.W. JENKINS &amp; SONS Co.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>4-6-1956</b>		REGISTRAR'S SIGNATURE <b>Wm. Hedrick</b>		
25. FUNERAL DIRECTOR <b>H.W. JENKINS &amp; SONS Co.</b>		ADDRESS <b>4905 York Rd.</b>		

THIS IS A PERMANENT RECORD.

PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. This certificate must be filed with the BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.



3833

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>				c. LENGTH OF STAY IN 1b <u>25 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2908 Erie Ave.</u>				d. STREET ADDRESS <u>2908 Erie Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Freda</u> Middle <u>O.</u> Last <u>Wiebking</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 2, 1895</u>	
9. AGE (In years last birthday) <u>60 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Dornbusch</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kuehne</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Rev. Carl C. Wiebking-2908 Erie Ave.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma 4 tumors</u> DUE TO (b) <u>Generalized Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>ap 19</u> , 19 <u>48</u> to <u>ap</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>ap 19</u> , 19 <u>56</u> , and that death occurred at <u>3: A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8106 Harford Rd</u> DATE SIGNED <u>Harold H. Burns</u>							
ACTUAL SIGNATURE <u>Harold H. Burns</u>		PHYSICIAN'S NAME (Type) <u>Harold H. Burns</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-17-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Parkville, Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>APR</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03810

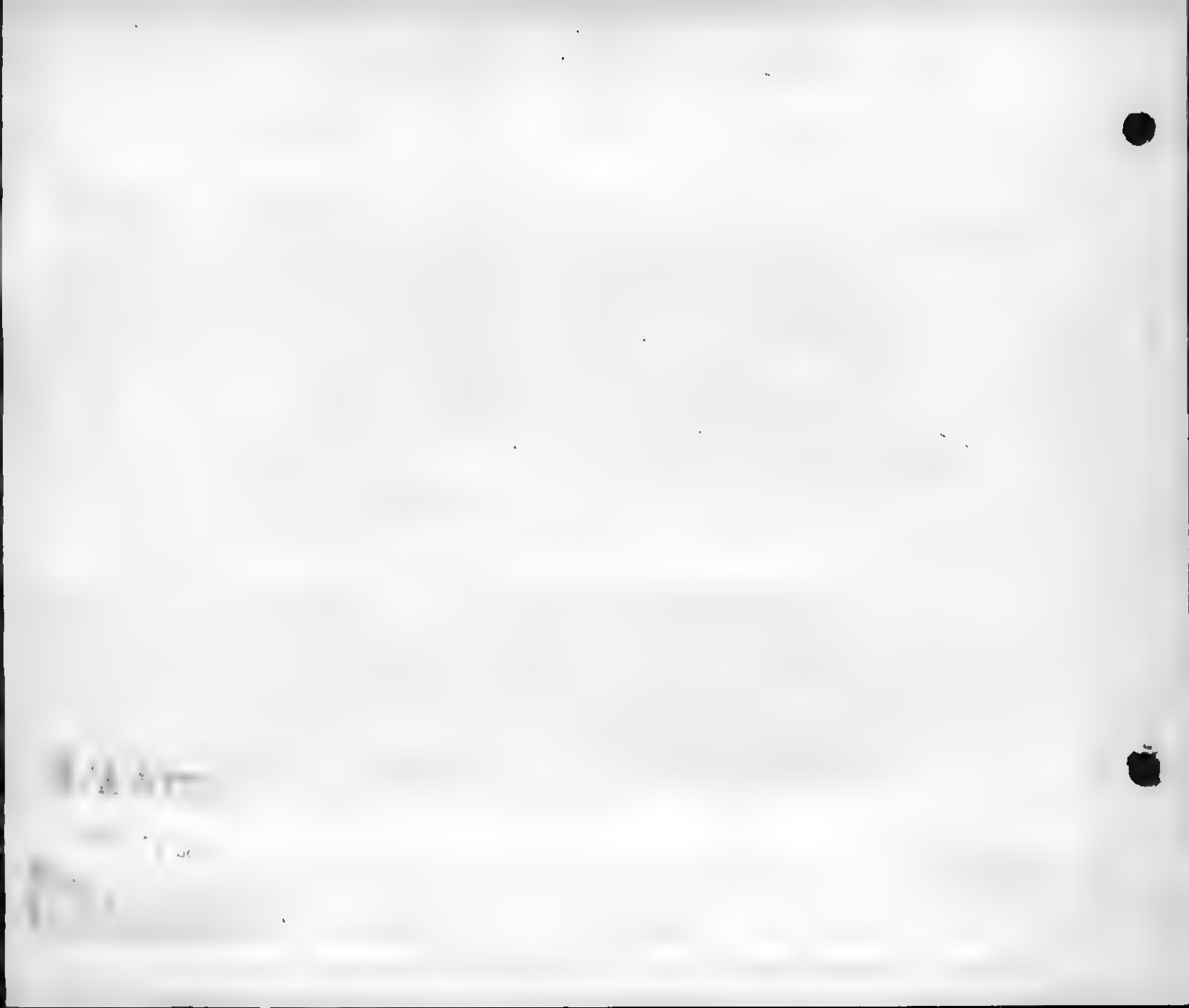
3834

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JONES CREEK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JONES CREEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7238 HUGHES AVE</u>				d. STREET ADDRESS <u>7238 HUGHES AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MATTIE</u> Middle <u>LEE</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1871</u>		9. AGE (In years last birthday) <u>84</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		10. BIRTHPLACE (State or foreign country) <u>MD</u>	
11. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOSHUA WARNER</u>				14. MOTHER'S MAIDEN NAME <u>JULIA BIST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MILDRED MAGERS</u> Address <u>7238 HUGHES AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> <u>4 years</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>SENILITY</u> DUE TO (c) <u>INANITION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Baltimore</u>				20f. (County) <u>Baltimore</u>		20f. (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>Nov. 23, 1955</u> to <u>Apr. 13, 1956</u> , that I last saw the deceased alive on <u>Apr. 11, 1956</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Towlin</u>				ADDRESS (Street, city or town, state) <u>6908 North Pt. Rd</u>		DATE SIGNED <u>4/14/56</u>	
PHYSICIAN'S NAME (Type) <u>Louis N. Towlin</u>				<u>Baltimore - 19 - md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Bright, Inc</u>				ADDRESS <u>6009 Harford Rd</u>		24a. REC'D BY REGISTRAR <u>Darson L. Farley</u>	
				DATE <u>4-17-56</u>		24b. REGISTRAR'S SIGNATURE <u>Darson L. Farley</u>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03811

3835

## CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fork</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mount Vista Rd.</u>		d. STREET ADDRESS <u>Mount Vista Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Willick</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurseryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Martin Willick</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Knox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-05-0500</u>	
17. INFORMANT Address <u>Edward G. Willick-Mount Vista Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LIFEMIA</u> DUE TO <u>CARCINOMA PROSTATE GLAND</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 yrs.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 9, 1949</u> to <u>4/15, 1956</u> that I last saw the deceased alive on <u>4/15, 1956</u> and that death occurred at <u>6:03 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> MD.		ADDRESS (Street, city or town, state) <u>Fork Md.</u> DATE SIGNED <u>4/17/56</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-18-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fork M. E.</u>	22d. LOCATION (City, town, or county) (State) <u>Fork Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lorraine Funeral Home - 7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>APR 19 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Hackett</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 41 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECEMBER

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Deputy Medical Examiner. The word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the Chief Medical Examiner's Office along with form IM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

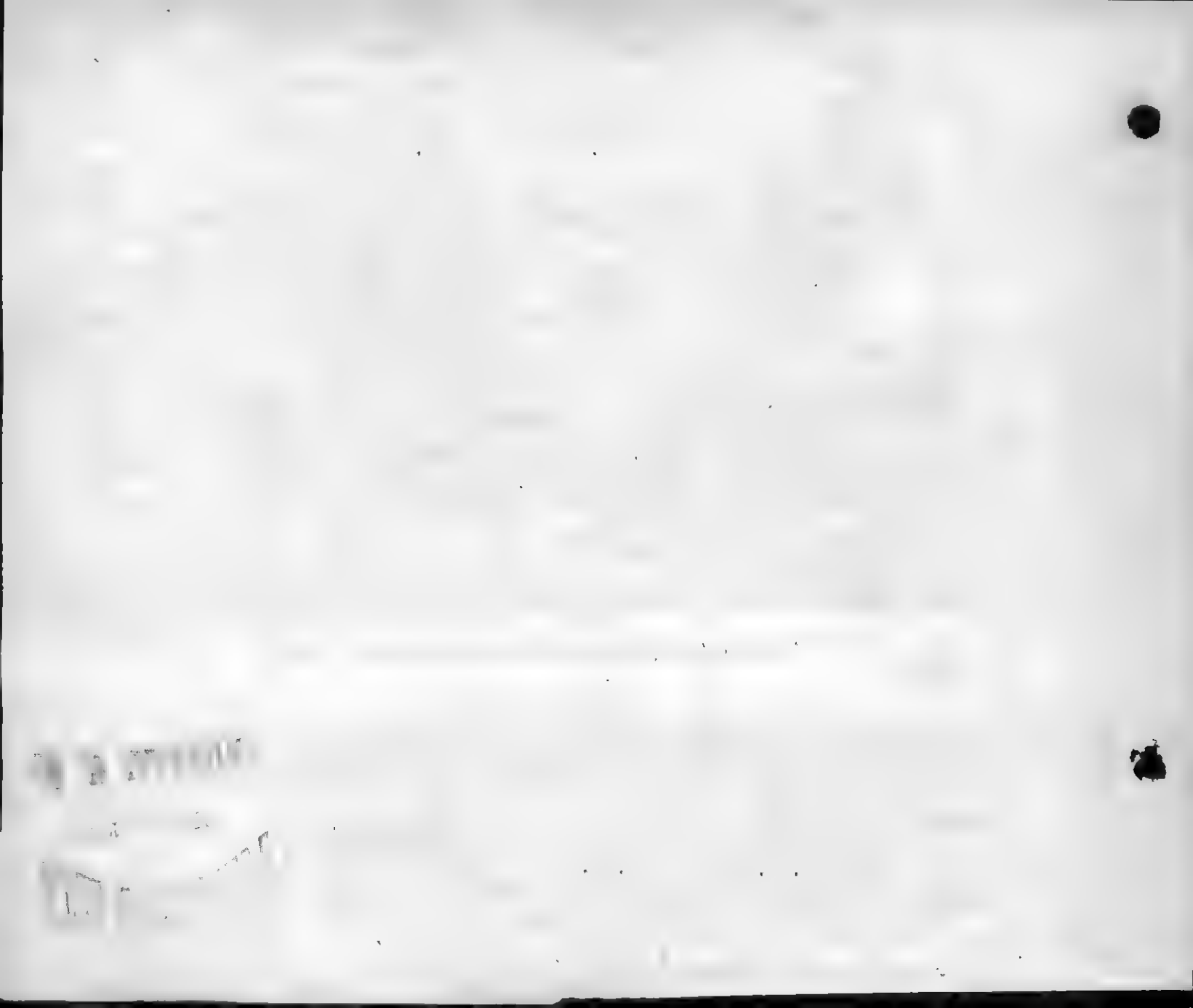
3836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03812

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>Balto</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>ST MARYS</b>	
b. CITY OR TOWN (If outside corporate limit, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10 h.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>First Alice M. Middle Wilson Last</b>		4. DATE OF DEATH <b>Month 4 Day 15 Year 56</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Unknown Wash. D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown John H. Walsh</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Alice M. Collins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Bronchopneumonia</b> (c) <b>_____</b> DUE TO causes listed, stating the underlying cause last. (c) <b>_____</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>_____</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>George S. M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George S. M. Kieffer, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>4-16-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/18/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geier Funeral Home</b>		ADDRESS <b>3605-14 St NW Wash DC</b>	
24a. RECEIVED BY REGISTRAR <b>DATE 4/18/56</b>		24b. REGISTRAR'S SIGNATURE <b>V E Harry</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

03813

2411 N. Charles Street, Baltimore

3664

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Turners Station</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Turners Station</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>111 Cherry Lane</b>		STREET ADDRESS (If rural, give location) <b>111 Cherry Lane</b>	
3. NAME OF DECEASED (Type or Print) <b>SALLIE</b>		4. DATE OF DEATH (Month) <b>4</b> (Day) <b>21</b> (Year) <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 20, 1875</b>
9. AGE last birthday <b>80</b> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ben Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <b>Mrs Jaunita Mandy 111 Cherry Lane</b>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause	(a) <b>Cerebral vascular accident</b>	<b>4 weeks</b>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <b>Hypertension</b>	<b>1 yr.</b>
	(c) <b>arteriosclerosis</b>	<b>1 yr.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-20, 1956**, to **4-21, 1956**, that I last saw the deceased alive on **4-20, 1956**, and that death occurred at **10:50 a.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

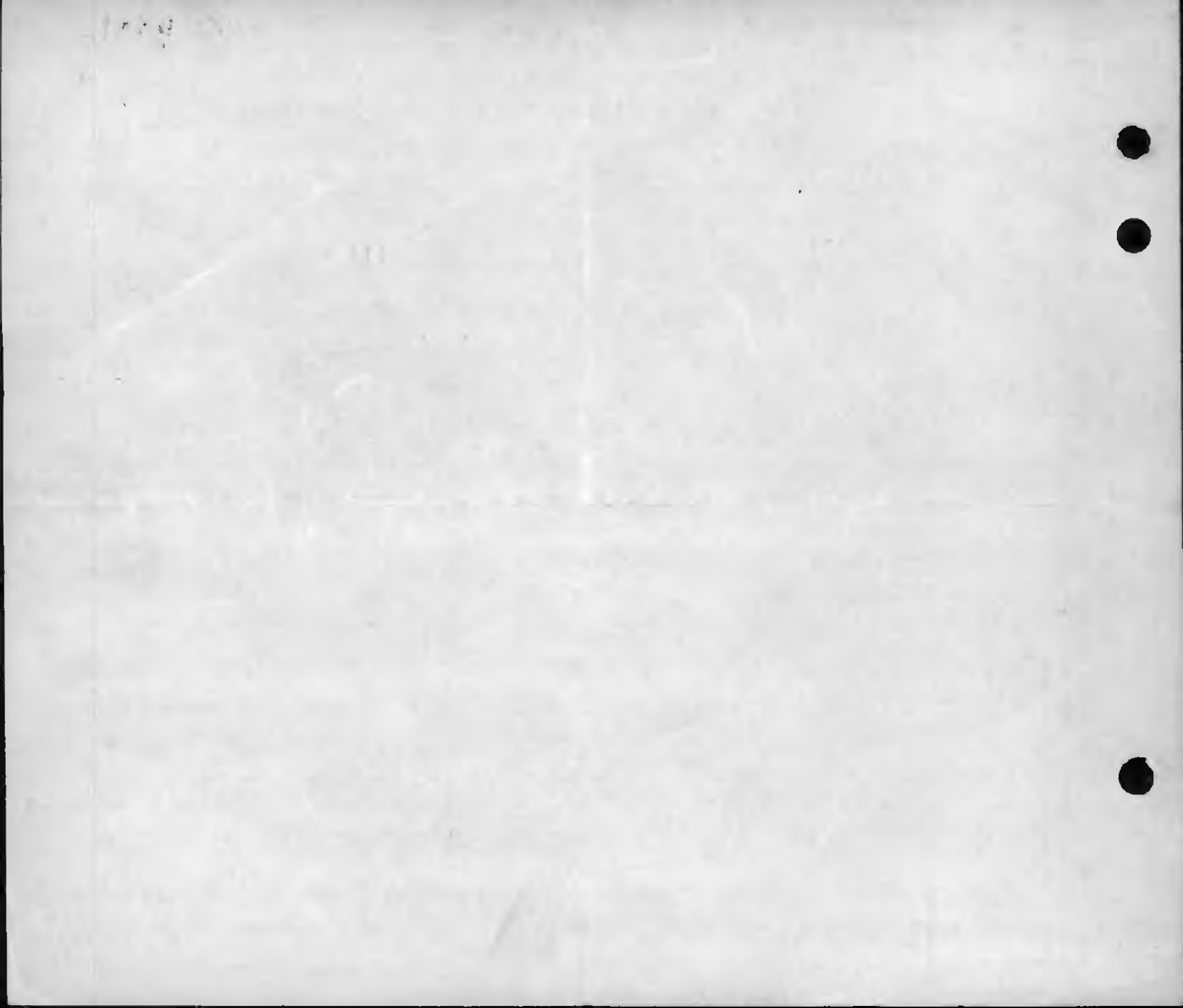
23. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>4-24-56</b>	NAME OF CEMETERY OR CREMATORY <b>St. Ambrose Cemetery</b>	LOCATION (City, town, or county) <b>Baltimore</b>	(State) <b>Md.</b>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <b>A. M. Hedrick</b>	FUNERAL DIRECTOR <b>Mrs. Frances K. Hemmley</b>	ADDRESS <b>Baltimore</b>	

4-23-56

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3665

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

038141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>S</u> b. COUNTY <u>ME</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AS ME #1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2621 LIBERTY PKWY</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>THOMAS</u> Last <u>YOWELL</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1885</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY YOWELL</u>				14. MOTHER'S MAIDEN NAME <u>VNK.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>216-701681</u>		17. INFORMANT Address <u>J.N. YOWELL - 2987 YORKWAY - DUNDALK</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>A-S-C-V Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>5 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>COATESVILLE, PENNA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brock Bradley, Dundalk, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 25 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner. The word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8008

BUREAU V. S.

APR 25 1952

RECEIVED